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MANUAL OF STANDARDS FOR REHABILITATION CENTERS AND FACILITIES.

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A 5-YEAR PROJECT TO SPECIFY STANDARDS OF REHABILITATION CENTERS AND FACILITIES RESULTED IN THREE PUBLICATIONS. THIS MANUAL INCLUDES THE CHARACTERISTICS AND GOALS OF REHABILITATION FACILITIES. THE STANDARDS FOR ORGANIZATION, SERVICES THAT SHOULD BE PROVIDED, PERSONNEL INCLUDED, RECORDS AND REPORTS, FISCAL MANAGEMENT, AND THE PHYSICAL PLANT ARE DESCRIBED IN SOME DETAIL. THE APPENDIX INCLUDES SUBCOMMITTEE REPORTS AND REPORTS ON MEDICAL SERVICES, PSYCHOLOGICAL SERVICES, AND SOCIAL WORK SERVICES. THE COMPANION PUBLICATIONS ARE "STANDARDS FOR REHABILITATION CENTERS AND FACILITIES" AND "STANDARDS SURVEY FORM FOR REHABILITATION CENTERS AND FACILITIES." (SL)

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manual of standards for rehabilitation centers and facilities

828 DAVIS STREET
EVANSTON, ILLINOIS

ASSOCIATION OF
REHABILITATION
CENTERS, INC.

MANUAL OF STANDARDS
FOR REHABILITATION CENTERS AND FACILITIES

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RESEARCH COMMITTEE STATEMENT

The Research Committee of the Association of Rehabilitation Centers had final responsibility for review of, and concurrence with, the standards and accompanying material. The standards material presented here have the full support and endorsement of the Committee.

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MANUAL OF STANDARDS FOR REHABILITATION CENTERS AND FACILITIES

PREFACE

The trend in our society toward greater concern for the disabled individual has stimulated a dramatic increase in the number of rehabilitation centers and facilities. For the most part, there has not been the widespread experience, comprehensive research, or broad theory within the field of rehabilitation to provide an adequate basis for the development of rehabilitation programs. As a result, many rehabilitation facilities have urged the formulation of guidelines for facility operation and management. The Association of Rehabilitation Centers, reinforced by the interest and backing of its members, initiated in 1960 a 5-year project to delineate standards and thereby to recognize and promulgate quality patient care in rehabilitation centers and facilities. The results of the project are presented in three publications:

1. Standards for Rehabilitation Centers and Facilities
2. Manual of Standards for Rehabilitation Centers and Facilities
3. Standards Survey Form for Rehabilitation Centers and Facilities

The three publications are best considered as companion documents. They are printed separately for ready reference and convenience in use, but they are basically related and interdependent. To illustrate, a facility desiring to upgrade its services may first wish to review the Standards document for an initial determination of the scope and level of the upgrading process, and the gap to be covered. The Survey Form can be utilized to provide a reliable and comprehensive examination of the facility and its program. The Manual then provides background material to assess the findings of the Survey Form, and descriptive information and suggestions on accomplishing desired changes. In brief, the three publications complement one another. The Standards indicates what the facility should be doing; the Manual explains why, and to some extent how, it should be doing certain things; and the Survey Form helps the facility determine what it is doing. The Standards and accompanying materials are intended for use by facilities which have the characteristics outlined on page one.

The Standards for Rehabilitation Centers and Facilities presents the standards and the basic principles underlying them. They are preceded by a preface which describes the background of the project, the a priori assumptions, and the methodology. The standards are yardsticks for measuring some of the practices and the program of the rehabilitation facility. They indicate desirable levels for quality patient[1] care. The areas covered by the standards are: goals, organization, services, personnel, records and reports, fiscal management, and physical plant.

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[1] In the absence of a general term, the word "patient" is used throughout the Standards publications to mean "patient," "client," "trainee," "member," etc.

This Manual of Standards for Rehabilitation Centers and Facilities has two purposes: first, to explain standards which are not self-evident or which have not been amply discussed in other places; second, to suggest how to implement the standards. Although there are many approaches to achievement of the standards, considerations of time and space have limited the number described in the Manual.

The Manual is organized by sections corresponding to the areas covered by the standards; for example: one section is devoted to "goals," another to "organization," etc. Within each section, the underlying principle is stated, followed by a discussion and then each major grouping of standards is stated and discussed.

The Standards Survey Form for Rehabilitation Centers and Facilities is an instrument for gathering and recording information to identify and evaluate the specific practices of facilities. It is intended for the use of facility personnel, consultants, and surveyors.

The development of the above materials in the 5-year course of the project had an early base in standards which evolved in other fields, such as hospitals, nursing homes, homes for the aged, and schools, which provided much data for early formulation of material. Particularly pertinent were those areas of overlap, such as in the organization of health care facilities, personnel administration, fiscal management, and physical plant.

In fields such as business and medicine, there are practices which in some instances have been established as accepted principles of operation and control. With varying degrees of modification, it was possible to transfer such principles to rehabilitation facility operation and control.

Data directly relevant to rehabilitation was provided through several means:

1. Close communication with the primary professional areas in rehabilitation facilities was established through the appointment of adviser-consultants to the project (appendix I.). Each adviser-consultant served as chairman of a subcommittee of his professional colleagues who collaborated to prepare recommended standards. The subcommittee members are listed in appendix II, preceding their reports.

2. Together, the adviser-consultants served as a multidisciplinary committee. In this capacity, the advisers helped synthesize the recommendations of the subcommittees and provide overall balance and perspective to the material as it was developed.

3. Representatives of rehabilitation facilities throughout the United States and Canada reviewed the materials and reports of the standards study at the annual workshops of ARC. Opportunities were provided for recommendations and consultation with the project staff in relation to the ongoing progress of the project.

4. The project staff used the formally established procedures described above, together with relevant association resources and activities, and personal visits to rehabilitation facilities, to gather information and knowledge in developing the standards material.

The collection, analysis, and application of the data to the development of the standards material was carried out with the assistance of a consultant in research design and methodology. Finally, overall policy direction for the project was provided by the ARC Research Committee composed of recognized leaders in rehabilitation who had demonstrated skill and experience in the conduct and supervision of research. The Research Committee had final responsibility for review of the standards material, and endorsement to the rehabilitation community.

Early in the project, it had been agreed that a major effort would be directed toward the demonstration of the utility of the standards materials. While considerable value could be attributed to the standards as a result of consensual agreement, an actual demonstration through application of the material in rehabilitation facilities could provide substantiating evidence. By 1963, the standards materials included a preliminary set of standards, a questionnaire, reports from the professional subcommittees, and a large collection of related data. This was ample material to initiate a pilot program of field visits. Accordingly, in 1963 project staff visited six rehabilitation facilities for the following eight objectives:

1. Obtain experience in field testing.
2. Informally test applicability of the standards.
3. Judge relevance of standards to diversity of facilities.
4. Test the standards questionnaire as a survey form.
5. Explore methods for evaluating program operation and management.
6. Evaluate standards' educational potential.
7. Judge attitudes of facility personnel toward application of standards.
8. Acquaint facility personnel with standards project.

The results of the pilot field visits led to revisions in the standards and the survey form, and prepared the way for formal field testing of the materials. Essentially, the formal field testing phase was designed to provide evidence as to the utility of the materials for upgrading rehabilitation programs, and indication of their applicability to the existing diversity of rehabilitation facilities.

Eleven leading rehabilitation facilities (appendix I.) were selected by the ARC research committee to represent the diversity in size, type of program, administrative setting, and community relationship. Each facility was asked to participate in the field test, and all agreed. A 6-month period was designated: January 1964 through June 1964.

Each facility completed and returned the revised survey form, reviewed and rated each standard, and made such changes as possible in their program to conform to the standards. Each of the facilities was visited by a staff member of the project for a 2- to 4-day period. During the visit, comparison was made between the survey form responses and personal observation of the program. An evaluation of the usefulness of the standards was made through appraisal of the effects of the standards upon the facility program and attitudes of the staff based on interviews of administrative and department heads, observation of the facility program, auditing of staff conferences, review of ratings of the standards and the running accounts, and review of records and reports.

At the close of the 6-month period, representatives of the participating facilities were called together for a 2-day meeting. The findings, as viewed by project staff, were presented for discussion, verification, and finalization. Agreement was reached as to the minor changes and clarifications needed in the standards.

The conclusions reached can be summarized as follows:

1. Based on the close approximation between the practices of the participating facilities which the professionally outstanding facilities and the requirements of the standards, it was concluded that the standards represent a desirable level of rehabilitation operation. The decision as to the close approximation was made by—
    a. The chief executives of the participating facilities.
    b. The department heads of the participating facilities.
    c. The project staff through observation of facility practices, and subsequently verified at the meeting of representatives of the participating facilities.
2. Based on the efforts made (or expressed desirability) of changing those aspects of the program not in conformity with the standards, it was concluded that the standards are a useful tool for the improvement of rehabilitation service.
3. Based on the similarity of the usefulness of the standards in all 11 facilities, it was concluded that the consistency of the standards as a mechanism for upgrading rehabilitation programs was established.
4. Based on the similarity between the information obtained from the survey form and that obtained from the field visits, it was concluded that the survey form is a valid device for recording objective data about facility operation.
5. Based on the similar findings of the above for all 11 facilities, it was concluded that the survey form is reliable and consistent as a measure of facility operation.

The above conclusions led to the final review by the ARC Research Committee, following which the standards were formally edited and printed.

The information and materials which had been gathered concurrently with the above developments were formulated into rationale, interpretation, and examples of standards and their fulfillment. The resulting draft, entitled "Manual of Standards for Rehabilitation Centers and Facilities," was circulated to participating facilities and the ARC Research Committee. A second meeting of representatives of the participating facilities was devoted mainly to a review of the Manual and suggestions for increasing the specificity of the discussion. Members of the Research Committee independently reviewed the Manual and made recommendations which provided the basis for a final revision.

Today's rehabilitation facilities vary in many dimensions, but the two most significant differences lie in the kinds of patients admitted and the kinds of services provided. These differences emerge clearly when one thinks of such diverse facilities as rehabilitation workshops, cardiac work classification clinics, physical medicine departments in hospitals, and comprehensive rehabilitation centers. Even among facilities of a given type, there are variations in intensity of service, size of program, financial resources available, and other factors germane to the rehabilitation effort. The development of a specific set of standards for each type of effort would have been an impossible task because of the wide range of variations. Partially for that reason, and partially because it is undesirable to prescribe arbitrarily and in detail what rehabilitation should accomplish, the standards are designed to be used as measures of effort in direct relation to the specific goals which the facility sets for itself. In this sense, goals are meant to refer to the purpose of the facility, stated in terms of objectives to be attained through the efforts of its personnel. The critical factor which must be recognized in the use of the standards by individual facilities is consistency between the goals of the facility and the program established to meet those goals.

In order to apply the standards, a valid definition of a rehabilitation facility is mandatory. The definition should be general enough to be inclusive of all rehabilitation facilities, and specific enough to be exclusive of facilities which are not rehabilitative in nature. Many definitions of a rehabilitation facility are currently in use and these have equal validity in focusing on one or another of the essential characteristics of the rehabilitation facility. These definitions have in common the following a priori assumptions:

1. Rehabilitation facilities serve handicapped, disabled individuals whose disabilities are usually of a permanent, residual type.

2. The resulting rehabilitation problems relate to disabilities which are more chronic than acute; inherent in them are a variety of complicating factors which may involve the physical, emotional, mental, social, and vocational well-being of the individual.

3. Rehabilitation minimizes the disadvantages of disability; it involves restoration and adjustment services which are both curative and educative.

4. These services are multiprofessional and interdependent.

5. Restoration and adjustment require the coordination and integration of these services into an effective functioning process.

6. The process of rehabilitation requires—

   a. Professional personnel who are technically competent in their fields, have knowledge of and appreciation for the other professional services, and are ethically responsible in all of their relationships.

   b. An established, organized means of communication and sharing of information among the staff.

   c. Relationship of the facility to the community.

   d. An adequate physical plant and equipment to provide for the safety and welfare of the patients and to promote the efficiency and effectiveness of the staff.

From these a priori assumptions, a conceptual definition of a rehabilitation facility was developed:

> A rehabilitation facility is an organizational and physical entity in which a soundly and ethically based program of integrated and coordinated services is provided. The services are directed toward the physical, mental, social, and vocational restoration and adjustment of handicapped, disabled children and adults. The services consist of evaluation, treatment, education, training, and placement, and are provided by competent personnel especially qualified in the various phases of the rehabilitation process.

This conceptual definition represents an ideal for a facility that is rehabilitative in its efforts; however, in actual practice, the concept is realized in only a small number of comprehensive, freestanding rehabilitation centers. In application of this conceptual definition to the realities of facility operation, it is necessary to specify the essential characteristics of a rehabilitation facility, as has been done on page one.

The standards will be effective to the degree that they are utilized by rehabilitation facilities in a continuing program of improving services to handicapped, disabled individuals. These standards can be applied through individual programs of organized, comprehensive self-evaluation and through surveys such as the Approval Program planned by the Association of Rehabilitation Centers.

Certainly, all problems will not be solved with the publication and application of the standards, but they will be brought out in bolder relief. Once identified and analyzed, problems become more amenable to solution. Difficulties are inherent in defining levels of quality in areas where the body of knowledge is incomplete at best. Many such areas exist in the field of rehabilitation. Nonetheless, forward motion required that a first step be taken. This project is that first step. It represents 5 years of intensive staff effort and the generous assistance of many knowledgeable individuals.[2] It can justifiably be considered a major stride into the realm of standard-setting and definition of quality and competency in the rehabilitation process. The Association of Rehabilitation Centers believes that standards for rehabilitation facilities will be of substantial value in the continuing task of defining and advancing the effectiveness of rehabilitation. The Association will continue to direct its best resources and talents toward further development and improvement of standards for rehabilitation facilities. It confidently anticipates the cooperation of everyone concerned in the uphill struggle to meet more adequately the human needs of disabled persons.

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[2] The project staff express their appreciation to the Research Committee of the Association of Rehabilitation Centers, the adviser-consultants and their committees, and the 11 rehabilitation facilities that participated in the field testing of the standards (appendix I). Without their assistance, and the help of many others too numerous to mention, the accomplishments of this project would not have been possible.

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REHABILTATION CENTERS AND FACILITIES

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ESSENTIAL CHARACTERISTICS OF A REHABILITATION FACILITY

The Standards materials were developed for application to rehabilitation facilities which have the following basic characteristics:

1. **The facility's major purpose is the rehabilitation of handicapped, disabled individuals requiring restorative and adjustive services in an integrated and coordinated individualized program.**
2. **Services in the following three areas are regularly and conveniently available; services in at least two of the three areas are provided within the facility by full-time, professionally qualified staff members.**
    a. **Medical**
    b. Psychological and/or Social
    c. Vocational and/or Educational
3. **The facility's program is rehabilitative in nature and not primarily directed to the provision of custodial and long-term care. More definitively:**
    a. **The facility's program is more than that required for extended nursing care.**
    b. **The facility's program is more than that required for extended sheltered employment.**
4. **The facility operates under a legally constituted governing body with responsibility for ongoing administration vested in a chief executive.**
5. **The facility's physical plant and equipment are adequate to insure the safety and welfare of the patients and to promote the efficiency and effectiveness of the staff.**

I. GOALS

PRINCIPLE:

The rehabilitation facility shall have established goals to govern the direction and character of its program. The operation of the rehabilitation facility shall contribute to the fulfillment of its goals.

A "goal" as defined in Webster's New International Dictionary (third edition, unabridged) is "the end toward which effort or ambition is directed; aim, purpose: a condition or state to be brought about through a course of action." The organized course of action undertaken by a rehabilitation facility is directed to the achievement of goals which vary in importance, urgency, and feasibility. The reason for every segment of that course of action is not always evident, but there exists an underlying purpose or goal. The issues are: (1) to what extent is the underlying purpose or goal in accord with patient needs, community needs, and the facility's resources? and (2) is the goal clearly understood by the patients, staff, governing body, and community?

Patient needs and community needs are more likely to receive consideration when they are incorporated into the facility's statement of goals. However, the mere enumeration of needs does not in itself assure responsiveness to them. The necessity for awareness and sensitivity on the part of the facility should be met by a stated procedure through which the facility can properly evaluate patient and community needs and appraise its own results.

The extent to which the facility is able to meet patient and community needs is determined by its resources. More limiting than insufficient funds or inadequate plant and equipment are lack of leadership and scarcity of qualified staff. Where such limitations exist, they will require the facility to state clearly in its goals how far it can go in meeting its service obligations.

Clear goals, consistent with one another, provide the common purpose which is essential for coordination of efforts. Many rehabilitation facilities are part of a larger institution. Examples are a department of physical medicine and rehabilitation in a hospital, or a rehabilitation unit of a university. Even though the larger institution has stated overall goals, it is still desirable for the facility to have its own statement of goals. This serves to identify the facility and make its special function clear; it helps project the facility's image; it gives the staff a strong sense of organizational purpose and helps them create a therapeutic environment which may spell the difference between successful and unsuccessful rehabilitation.

In addition to providing direction and serving as a rallying point for staff and patients, goals provide a yardstick for measuring the performance of a rehabilitation facility. Whether performance is evaluated by the facility staff, by consultants, or as part of an approval program, the yardstick remains the same: evaluation should have as its basis the goals of the facility.

A major factor in achieving quality services lies in the application of the goals principle, because self-evaluation is an essential part of the application process. Self-evaluation in turn leads to more effective utilization of resources and a more cohesive, coordinated, internally consistent program.

STANDARD A.

The rehabilitation facility shall have established, stated goals. These goals shall be:

1. **Consistent with the minimum requirements for definition as a rehabilitation facility.**
2. **Consistent with its corporate charter or constitution.**
3. **A matter of official record in consolidated form.**
4. **Readily available to:**
    - a. **Staff**
    - b. **Patients**
    - c. **Sources of referral**
    - d. **Purchasers of service**
    - e. **Contributors or supporters**
    - f. **Related public**

The principle discussed above has general application. The establishment of goals which are clearly defined and consistent with one another will improve the efficiency and effectiveness of any organization and facilitate evaluation of its program. The rehabilitation facility has a particular responsibility to define its goals and to make them known because (1) the lives and well-being of people are directly affected by its activities, and (2) rehabilitation facilities are comparatively new on the health scene and therefore are not well understood by the public.

A statement of goals should define the nature of the rehabilitation facility and describe its limitations. It should also provide guidance for short-range, intermediate, and long-range planning.

Obviously a facility offering the minimum services differs markedly from a comprehensive facility, and the range between these two types is wide. An example of the goals of a particular rehabilitation facility at the minimum end of the scale is:

> To assist individuals who have cerebral palsy make a successful adjustment to the labor market through the provision of social casework, vocational counseling and testing, job tryout, and job placement services.

In addition to the above, the statement would indicate more specifically the age restriction, residence and financial requirements, and any other limitations in effect.

An example of a statement of goals for the comprehensive facility is:

> To assist individuals unable to maintain physical, social or economic responsibilities because of severe disabling circulatory, neuromuscular, respiratory and metabolic illness to achieve a more normal existence through the provision of medical, psychological, social, vocational, education and recreational services.

To facilitate planning, three levels of goals might be set down: (1) short-run, immediate goals which apply to facility operations for the fiscal year; (2) intermediate goals which guide planning for a two to five year period; (3) long-range goals which provide underlying continuity and give the facility its basic identification. A full understanding of ultimate objectives is essential to the establishment of appropriate immediate goals. The three levels of goals should be consistent with one another and with the legal status of the facility. Only the long-range goals ordinarily will be found in the charter or bylaws of the facility. Major changes in the program of the facility that depart from established goals should have the prior approval of the governing body.

In a rapidly changing society, a facility which is sensitive to community needs will find that long-range goals do not provide the desirable practical specificity appropriate to week-to-week operations. Conversely, specificity without overall direction can result in lack of coordination and fragmentation of program. The establishment of goals at three levels–short-run, intermediate, and long-range–can provide the balance required.

To be of maximum usefulness, goals should be formulated by the governing body and set forth formally in a statement of purposes. Such a statement, suitably adapted to different audiences, should be distributed to the staff of the facility, its patients, community agencies, sources of referral, purchasers of service, contributors and supporters, and the facility's related public. The statement may be incorporated in the employee's handbook, patient's brochure, annual report, and other publications of the facility. Variations in the statement may be necessary to make it clearly understood by the readers to whom it is directed but such variations should not distort the goals or result in inconsistency among the statements. Fulfillment of this aspect of Standard A is part of the basic community relations responsibility of any facility.[1]

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[1] Community relations activities are further discussed in the section on "Services."

STANDARD B.

The rehabilitation facility's goals shall be specific. Goals shall relate to:

1. **The human needs which the facility proposes to fulfill.**
2. **How the program relates to the accomplishment of the goals.**
3. **The restrictions and/or special conditions applying to patients served and to services provided.**

To the extent possible, goals should detail the needs to be served, the services to be provided, and the requirements for admission. Goals should specify the particular human needs to be met as they relate to the individual's functional situation and the influence of his own environmental circumstances, be they physical, social, and/or occupational.

The following are examples of human needs which are likely to be rehabilitation goals:

- Physical independence. In pursuing this broad goal, the patient's potential will be evaluated to determine how realistic the goal may be and how far the institutional program can support the specific patient goal. For some, achievable physical independence will not extend beyond a mastery of the rudiments of self-care. In this case a facility should be prepared to provide the range of services needed for all of the attainable objectives associated with independent living–from bowel and bladder training to the fitting of, and training in the use of, assistive devices.

- The necessity for a person to be productive. The program of a facility pursuing this goal may range from the provision of home-bound employment or sheltered workshop placement to job placement in competitive employment and follow-up.

- The establishment of personal/social relationships. Attempting to meet a goal of this kind again involves a broad range of services. At one end of the scale would be the provision of occasional recreational activities; at the other end would be a full complement of social, psychological and psychiatric services to help the patient achieve his optimal personal and social development and to integrate him into the community's social structure. Such goals as "happiness," "a full life," or "overall adjustment" are too vague for program planning and do not contribute to an understanding of the facility's services. A goal of "renewed faith and peace of mind," for example, does not differentiate the rehabilitation facility from a religious institution.

If a facility is to deal with human needs, it is obligated to specify the scope of its resources and the limitations of its program. Available assistance must be balanced against the individual patient's needs, his potential, and his environmental circumstances. In other words, each facility owes it to itself and to its patients to recognize not only what it can do, but what it is not equipped to do.

The facility's goals should be applied in a consistent manner to all facets of its program. For example, the selection of patients and the manner in which they are served should be based on the overlap between the goals of the facility and the patient's needs. Similarly, the size and nature of the budget, staffing patterns, acquisition of equipment, and evaluation of new concepts and approaches should be related to the stated goals.

STANDARD C.

The goals of the rehabilitation facility shall be regularly reviewed by its staff and governing body.

With the passage of time, new needs arise in a community and old ones change. To maintain a program which is related to community needs and to changes in clientele, availability of staff, technical developments, fiscal support, and similar factors, the facility should review the reasonableness of its goals periodically and in depth.

An effective technique for reviewing goals is to have department heads submit, at the time of annual budget preparation, a statement of goals to which the program and supporting budget relate. It is helpful for such a statement to be developed at the time when the departmental staff is reviewing the previous year's goals and accomplishments. The goals proposed by each department can then be reviewed by the chief executive for consistency with long-range plans and other objectives. A department head meeting is also helpful to synthesize departmental goals with overall facility goals. The final product should, of course, be presented to the governing body for its consideration.

Other techniques for review of goals are the formation of special committees and the use of outside personnel for evaluative purposes. Whichever approach is applied, it should include careful examination of the program of the facility to ascertain if it contributes to achievement of the self-chosen goals of the facility. Proposed changes in goals should include recommendations regarding requisite services, operating procedures, and staff alignment. The restated goals also should be consistent with the definition of a rehabilitation facility, consistent with the legal status of the facility, and should be specific, attainable, and flexible. The new goals should be distributed to the staff and other affected individuals and agencies.

Facilities which have never formally developed or reviewed their goals will particularly find that the process is a valuable experience in self-examination and heightened perspective.

II. ORGANIZATION

PRINCIPLE:

The organizational structure of the rehabilitation facility shall contribute effectively to the implementation of its goals.

"Organization and administration" refers to the manner in which facilities, equipment, services, and personnel are brought together to achieve a program of rehabilitation for the individual patient—a program which meets his particular problems and needs as completely and thoroughly as possible. The ultimate measure of a facility's organizational and administrative structure is how well it combines these resources in the best interest of the patient and how effectively it contributes in this way to achievement of the facility's goals. Final authority for determining the structure is vested in a governing body which sets policies for the institution in relation to stated goals. Responsibility for building the structure and making it work is assigned by that body. The functions of organizing, directing, and controlling services (and personnel) are performed by those to whom the necessary authority has been delegated.

Accepted principles of management provide reliable guidelines for structural development, but the organizational structure of a rehabilitation facility has unique demands upon it because of the degree to which services must be coordinated and integrated. The interdependent nature of the total rehabilitation effort requires that the personnel involved assume responsibility not only to their own service, but also to the relationships which make integration and coordination of all services possible.

The skeletal structure of organization is fundamentally the same for any rehabilitation facility, whether it is a freestanding independent center or a unit of a larger institution. Some of the elements which comprise the structure may be farther removed from one another in the latter setting, but the basic relationships between those elements remain unchanged. For example, in the discussion that follows, the term "governing body," when appropriate, refers to the rehabilitation board or to the administrator of a larger institution responsible for the rehabilitation unit.

STANDARD A.

The rehabilitation facility shall be, or be part of, a legally constituted corporate entity with a charter or constitution and bylaws which are in accordance with legal requirements affecting its organization.

1. The charter or constitution shall:

    a. Identify the corporate entity.
    b. State the object of the corporate entity.
    c. Describe categories of, and qualifications for, membership.
    d. Describe methods of amending the constitution.

2. Bylaws, which may contain the articles listed under the constitution, shall, in addition:
    a. Provide for a governing body.
    b. Describe qualifications for membership in the governing body, election, and tenure of office.
    c. Establish regular and special meetings of the governing body, in no event less than three meetings each year.
    d. Provide for committees of the governing body.
    e. Describe the parliamentary procedures which shall be followed in the conduct of business meetings.
    f. Describe methods of amending the bylaws.

The legal status of the facility must be appropriate to its goals and program. Whether the facility be voluntary, publicly owned, or proprietary, its charter, constitution, or bylaws should make general provision for its program. If the facility is a governmental unit, there should be an appropriate statutory basis for its existence. If the facility is part of a larger institution, there should be justification in the institution's charter or constitution for the specialized activity of a rehabilitation department.

Customarily, consultation is obtained in drawing up a charter or constitution and bylaws to insure conformity with legal requirements as well as with the specific items listed under this standard.

STANDARD B.

The rehabilitation facility shall have a formally constituted governing body with legal and moral responsibility for the formulation of broad policy directed toward the establishment and operation of the program.

1. The governing body shall be constituted so as to provide effective leadership, resourcefulness, and stability for the facility.
    a. Membership on the governing body should reflect a cross section of leading public-spirited citizens of the community.
    b. No individual shall retain membership on the governing body when such membership constitutes a conflict of interest.
    c. Quorum requirements of at least one-third of the membership shall be in effect.
    d. Minutes of meetings shall be recorded, safeguarded, and available for review as authorized by the governing body or the chief executive.

2. **The governing body shall have the responsibility required for the establishment and maintenance of high standards of operation for the facility, and for its continuing development.**
    - a. **Rehabilitation needs of the community shall be ascertained and interpreted periodically.**
    - b. **An organizational plan for the facility shall be in effect, together with appropriate rules and regulations.**
    - c. **A qualified chief executive shall be appointed.**
    - d. **Facilities and equipment consistent with needs shall be provided.**
    - e. **Adequate financing shall be provided through securing sufficient income, budgetary control, safe administration of trust funds, and a good recordkeeping system.**
    - f. **General personnel policies shall be established and in effect.**
    - g. **Annual and other meetings as may be required shall be conducted to report to the membership on the affairs of the corporation and the activities of the facility, to elect members to the governing body, and to carry out such other business as required by the bylaws.**

The concept of the governing body[2] is as basic to the rehabilitation facility as it is to other types of health care institutions. The bylaws of the facility should set forth the responsibilities of a governing body, describe the qualifications for membership, and establish rules concerning frequency and conduct of meetings, committes, and amendments. The governing body is the final authority for the facility's operation; it should provide competent judgment and continuity of leadership, both of which are vital to the establishment and maintenance of high standards. Because of the key role which the governing body plays in the operation of the facility, it must be so constituted that it can provide effective leadership and stability. The size of the governing body, as an example, may be so small as to limit its resourcefulness or so large as to hamper its functioning. Obviously no fixed number represents the optimum size of the governing body, but an approximate range of between ten and thirty members should permit the desirable qualities to emerge. Most critical to the success of the governing body's functioning is that its membership be composed of competent individuals who are deeply interested in the goals and program of the rehabilitation facility. This interest will be reflected by the amount of time and resources which each member devotes to his position. One method of sustaining interest is the injection of new spirit into the governing body by selection of new members to replace those whose tenure has terminated. Therefore it is desirable, although this is not stated as a standard, that membership on the governing body be limited in time and that terms of office be staggered.

The resourcefulness and stability provided by the governing body has the greatest range and depth when the resources, needs, and attitudes of the community are reflected in its membership. This does not require a mechanical apportionment of members to rep-

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[2] For further discussion concerning this and succeeding sections pertaining to the governing body, see Malcolm T. MacEachern, Hospital Organization and Management, Berwyn, Illinois: Physicians Record Co., 1962, Chapter IV.

resent defined segments of the community; rather, it requires individuals who can sensitively coordinate the facility and the community. Such coordination will help assure the necessary community support and understanding of the facility's activities on the one hand, and the optimum contribution of the facility to the community's needs on the other. Proprietary, governmental, and denominational rehabilitation facilities are not bound to the necessity of a representative governing body. When it is not possible to reflect all community interests within the governing body, advisory boards can be effective and are recommended. In smaller communities, the opposite problem may prevail: community interests may be limited and it may be next to impossible to find a member of the governing body who does not face a conflict of interest. The leading citizens in small communities may be the sole source of goods or services which the facility requires. If the members of the governing body adhere to high ethical standards, then actual or potential conflicts of interests will be minimized.

The size and scope of the facility's operation will determine how frequently the governing body should meet and to what extent it needs to organize itself into committees. At the minimum, the governing body shall meet every four months. At these meetings, at least one-third of the members of the governing body should be present. At least annually, a special meeting is required to report to the membership on the affairs of the corporation and the activities of the facility, and to carry out such other business as is required by the bylaws. The deliberations of this meeting as well as of all formal meetings of the governing body and its committees need to be recorded in the form of minutes for administrative, accreditation, and legal reasons. Such minutes should be safeguarded and available for review as authorized by the governing body or the chief executive.

The longer the intervals between meetings of the governing body, the more important it is for an executive committee to be formed and given the authority to act, subject to review by the governing body. Some areas may require study in depth which must be done by a committee, irrespective of the meeting intervals of the governing body. Finance, for example, may require particular work-up by a committee. The principle involved is that the governing body organize itself so that it can most effectively meet the needs of the facility in relation to the community of which it is a part.

The governing body's primary responsibilities are the establishment of policy, liaison with the community, and financial viability of the facility. These are highly interrelated areas. The development of policy depends to a large degree on knowledge of the needs of the community, and relations with the community will depend on the extent to which policy leads to quality services. Accomplishments in these first two areas, in turn, will affect the degree to which the community contributes financially to the facility for a strongly interactive relationship.

The policies formulated by the governing body will affect the organizational and financial structure of the facility, its program, personnel, plant, and equipment. Through these policies, the governing body strives to maintain high standards for the facility. While members of the governing body may not have the professional training which qualifies them to evaluate all rehabilitation services, they should be cognizant of the field through the work of committees, consultants, reports of the staff, and personal observations.

Community relations take two directions. In one, the governing body ascertains the needs of the community to provide guidance for the direction of the program. Community needs can be ascertained through periodic surveys of referring agencies, private practitioners, and knowledgeable individuals as well as through analysis of health and economic statistics and reports. Such surveys might best be conducted in cooperation with other health, social, and planning agencies for more accurate data and as a step toward improved coordination of services to meet the needs of the community. Activity in the other direction consists of interpreting to the community the nature of the rehabilitation program and its role in the community health structure.

Assurance of financial responsibility is a critical function of the governing body. Even in those facilities that are heavily endowed or are tax-supported there must be an accounting of funds and overall budgetary control. For the majority of facilities that operate at a deficit which is not easily met, the governing body must seek resources and develop fund raising techniques to provide for the program which it has developed and approved.

The governing body remains effective to the degree that it concerns itself with broad policies of operation and control. If policies are adequately conceived and the responsibility for implementation is given to a qualified individual, then the governing body has discharged a major responsibility. In the final analysis, responsibility for carrying out policies of any governing body must rest with one individual–the chief executive. For effective application of this standard, the responsibilities of the chief executive of a rehabilitation facility must be clearly stated and formally established by the governing body. The unique problem relating to the appointment of a chief executive qualified to operate a rehabilitation facility lies in the term "qualified." The field of rehabilitation, in its present state of development, has not defined with sophistication the necessary qualifications of the chief executive. Quality in a chief executive can be judged on the basis of three criteria: educational background, experience, and performance on the job. The training which a chief executive has received obviously is one measure of his ability to function effectively, particularly if his education has been directly related to the job demands of the facility. Experience can also be taken as an indication of qualification, but, as with educational background, it should not be judged apart from on-the-job performance. The current performance of the chief executive on the job is central to any determination of qualification. If he is performing at a high level of success, then his qualifications, whatever they may be, are adequate. Qualifications may vary widely and are dependent, in effect, upon the operational demands of the individual facility. Therefore they must ultimately be judged in the light of successful performance.

It is recommended that the chief executive have at least a bachelor's degree from a college or university. Such background should consist of a major in some area which is demonstrably of practical value in the administration of a rehabilitation facility. Above this limit, the amount of education is not as important as experience and job performance.

STANDARD C.

The chief executive of the facility shall have the authority and be responsible for direction of the facility's operation in accordance with policy established by the governing body. He shall:

1. Establish and maintain effective liaison with the governing body.
    a. He shall be present at all meetings of the governing body and standing committees, except when his personal status is under consideration.
    b. He may be an ex-officio member of the governing body without voting privileges, except when it is required by law that he have voting privileges.
    c. He shall orient new members of the governing body to the operation of the facility.
    d. He shall assist the governing body in the formulation of policy by presenting and interpreting operating reports, financial statements, short-term and long-term plans, changing concepts and standards, and related information.
    e. He shall assist the governing body as required in such functions as fund raising, community relations, and related duties.
2. Coordinate and direct activities of the facility in accordance with the policies of the governing body.
    a. Develop the organizational structure for the facility through delegation of authority and responsibility, establishment of lines of communication, preparation of current organization charts, organization manual, written policies, flow charts, and related staff educational material.
    b. Maintain personnel policies through involvement in personnel recruitment and selection, personnel training, employee relations, and through development of job descriptions, table of organization, and related areas.
    c. Control the operation of the facility through day-to-day decision and authorization of expenditures and other procedures in accordance with the policy established by the governing body.
    d. Upgrade the operation of the facility by studying and analyzing reports of the various departments; comparing the performances against budgetary, administrative, and professional standards; and taking appropriate corrective measures.
    e. Keep abreast of rehabilitation developments locally and nationally.

The chief executive translates the policy decisions of the governing body into the day-to-day activities of the facility. It is therefore important that the chief executive be given adequate authority to carry out his responsibilities. Just as a governing body has a right to expect that a chief executive not abuse the authority delegated to him, the chief executive has a right to expect a governing body to exercise self-restraint so that he is not undermined in the discharge of his duties.

The chief executive can be responsible only to the whole governing body. To avoid a conflict in roles and interests, it is best that he be an ex-officio member of the governing body without voting privileges, except when it is required by law that he be a voting member. In any event, the chief executive should attend as many of the meetings of the governing body and its committees as possible to be fully informed and to inform, except when his personal status is under consideration. Basically, a free flow of information must exist between the governing body and the chief executive. The latter should set the pattern by providing new members of the governing body with a full report of the various aspects of the facility's operation, including progress toward the realization of program objectives. This may include a review of the development of the facility; a tour of the facility; discussion of its current goals, program, and problems; the relationship of the facility to professional groups in the community and to the public; and review of anticipated needs and tentative plans. Maintaining harmonious relations with members of the governing body is a continuing responsibility of the chief executive.

The chief executive assists the governing body in the performance of its functions by presenting and interpreting operating reports, financial statements, and related information.[3] He should also help keep the members abreast of developments in the field by discussing changing concepts, trends, and standards.

The chief executive carries out some of his responsibilities by helping to establish an organization appropriate to the goals of the facility, and by delegating authority and assigning responsibility to qualified staff members. Even when the chief executive is professionally competent in a clinical service, he should not attempt to supervise the service unit directly (unless the facility is small), but should appoint a department chief. Thus, an occupational therapist who is chief executive of a rehabilitation facility should not also attempt to direct the occupational therapy department, unless the size of the facility requires such a dual role. Conversely, the chief executive cannot relinquish his overall responsibility for the quality and appropriateness of the services. As chief executive, he must see to it that medical and other care is provided in accordance with the objectives and standards of the facility.

The chief executive is responsible for the recruitment, selection, and development of staff. Therefore, he should see to it that appropriate personnel procedures are established to facilitate recruitment and assure retention of competent staff. Recruitment procedures will vary, of course, according to the size, location, and program of the facility and labor market conditions. It is best that the decision to hire an applicant for a professional position be made with the advice of the head of the department involved. A department head generally will be better able to judge the professional competency of the applicant. The administrator and his staff must also be sensitive to the applicant's capacity to adapt and contribute to the teamwork of the facility. Personnel relations in large measure reflect the conduct of the chief executive. If the chief executive demonstrates his sincere commitment to harmonious teamwork by applying it directly in his own position, he will directly influence the staff to do the same. The chief executive must be sensitive to staff attitudes and feelings. An "open door" policy may not be enough. Alertness to potential problems, complaints, and conflicts makes preventive action possible and corrective action easier. In addition to periodic department head meetings, the chief executive or his designate should encourage informal contacts.

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[3] For a more detailed analysis of the function of the chief executive in relation to the governing body, see Ray Johns, Executive Responsibility, New York: Association Press, 1954, Chapter VI.

It is helpful for the chief executive to formulate guidelines concerning the development and maintenance of policies and procedures covering:

1. The definition of policies and procedures.
2. The source of the policies and procedures.
3. The method of communicating policies and procedures.
4. Exceptions and appeals.

The formulation of personnel policies and related material is documented in several sources.[4] The section on "Personnel" covers this subject more fully.

The chief executive should also keep abreast of, and contribute to, rehabilitation developments locally and nationally. The adequacy of the time and effort he expends in this direction can be measured not merely by the number of organizations of which he is a member but by the degree to which the program of the facility is utilizing the latest recognized techniques and attacking the appropriate, current problems of the community.

STANDARD D.

The rehabilitation facility's organizational structure shall be designed to promote efficient and effective application, coordination, and integration of the program essential to meeting its goals.

1. **There shall be policy established within the facility governing the delegation of authority and responsibility.**
2. **Staff meetings shall be held at intervals appropriate to the administrative and professional needs of the facility.**
3. **There shall be involvement of staff in constructing agenda and in departmental decision making.**
4. **There shall be an established and understood procedure for resolving interdepartmental conflicts.**

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[4] Ray Johns, op. cit., Chapter V.
Rensis Likert, New Patterns of Management, New York: McGraw-Hill, 1961.

5. The chief of each department shall be responsible to the chief executive or his designate for fulfillment of his assigned duties. The chief of each department shall:

- **a. Carry out the administration of his department in keeping with policies established by the governing body and by the chief executive.**
- **b. Direct the department's activities, including the determination of job duties, within the scope of the responsibility delegated to him.**
- **c. Have direct access to the chief executive or his designate.**
- **d. Participate in decisions affecting his department, such as budgeting, staffing, space allocation, travel, client selection, in-service training, consultants, public relations, and program development.**
- **e. Be responsible for employee scheduling, time sheets, job performance, and periodic rating of the employees' effectiveness.**
- **f. Be responsible for and closely supervise interns, trainees, aides, and volunteers assigned to his department.**

The multiplicity of services in the rehabilitation facility requires the minimization of interservice rivalries and the integration and coordination of services. Fundamental to such an accomplishment is mutual respect among the service units or departments for the integrity and worthwhile contribution of each. This is fostered by: (1) staff knowledge of the nature and goals of each service unit; (2) clear focus upon the needs of the individual patient; (3) a system of values that minimizes the influence of differences among professions; (4) clearly written descriptions of the proper area of functioning for each service unit; (5) clearly understood lines of authority; and (6) a high level of staff morale.

Staff relationships are healthier when everybody knows who reports to whom, and why. The rehabilitation facility's governing body and its chief executive should recognize the necessity for delegation of authority and assignment of responsibility by providing clearly written policies to govern that action. The advantages of such policies are twofold: (1) delegation of authority takes place more easily and with consistency; and (2) there is staff understanding of the basis for such delegation by the chief executive and by others whom he designates. His responsibility in this regard was discussed under Standard C.

Holding regular staff meetings is another effective means of promoting interservice understanding and integration. The section on "Services" further discusses the nature of these meetings. In general, they will be more meaningful and appropriate when staff is involved in suggesting agenda. The same holds for departmental decision making. Staff involvement is not meant to imply that departmental decisions must be approved by staff, but rather that staff should be given an opportunity to express themselves concerning those issues which affect them. It is not always possible to make decisions in accordance with staff preferences, but the satisfaction of having their preferences considered and having the reasons for the decisions explained contributes to staff acceptance and implementation of the decisions.

An organizational structure which promotes interservice cooperation and harmony can do much to avoid or minimize conflicts. The basis for setting up "sections," "units," "divisions," and "departments" varies among rehabilitation facilities. Not even the terminology is uniform. It is not possible at this time to present a standardized organizational breakdown. It is possible, however, to state that units which have equivalence in their responsibility for patient care should have equivalent administrative status.

III. SERVICES

PRINCIPLE:

The rehabilitation facility shall provide services essential to accomplishing the goals that it established in accordance with the standard on goals. These services must be of such a quality and so applied that they constitute an effective functioning program.

The rehabilitation program is more likely to be effective when the facility can offer visible assurance that the relationship between services and goals is direct and close. It is helpful to patients, staff, and the community to be able to see this relationship clearly. While it is necessary for the facility to provide those services required by its goals, it is also necessary for it to exercise careful control over the progression of services into areas not covered by the goals. Services inevitably develop as new techniques and concepts evolve. How they can best be utilized will be revealed through reappraisal of the goals of the facility.

Those services relevant to the goals are best provided within the facility, by the staff of the facility. Services which are supplemental to those required by the goals may be contracted for outside the facility. The level of quality of the services provided on either basis should not be less than that required for the accomplishment of the goals. To determine whether such accomplishment is in fact taking place, some means of verification must be employed. Follow-up of patients is one means through which the effect of services can be ascertained.

STANDARD A.

The rehabilitation facility shall provide services required to fulfill its goals. The facility shall:

1. Engage a competent staff as required to provide the services.
2. Describe to its staff, patients, other agencies, and its public the services which it provides.
3. Admit only those patients whose needs are consistent with the services provided by the facility.
4. Assign to each patient a professionally competent staff member who shall at all times be responsible for managing the patient's program (the staff member assigned may change at various phases of the program).

Usually it is possible to describe only in broad terms the services required to fulfill a given set of goals. However, the more specific a facility is in stating its goals, the easier it is to determine what services are necessary. Definitive determination of the type and extent of services essential to a facility's goals must rest mainly upon the judgment of professionals in the field and the state of current professional knowledge. Admittedly, there is room for differences of opinion. The fact that many questions cannot as yet be answered with precision points up the need for evaluative studies to determine the effectiveness of services and to establish causal relationships.

To clarify the discussion, the term "services" as used in this section refers to the evaluative and treatment components of a professional discipline, rather than to an organizational element such as a department. If a facility purports to make a given service available, this generally means that the facility should have at least one full-time professionally qualified staff member to provide the service. This allows for a full commitment to the concepts and techiniques relevant to rehabilitation and for the formal and informal communication central to the concept of integration and coordination of services. The major services, their components, and corresponding personnel are presented in appendix III.

The facility has an obligation to the population it serves—both directly and indirectly—to specify clearly and completely the kinds of services it offers, the restrictions which apply to those services, and the type of clientele who are eligible for admission. It is possible to misjudge the services a facility provides if such judgment is based solely on the disciplines represented by staff members. For example, social adjustment services are not always provided when a social worker is on the staff. If her function does not include evaluation or treatment of the patient's social situation but is limited to investigating financial resources, obtaining clothing, arranging transportation, or referring to other agencies, then the social worker in this instance is contributing to early convalescence, but not to social adjustment. This problem relates to the wide range of facilities discussed on page vi, and to the importance of accurately reflecting the position of the facility in the spectrum of minimum to comprehensive services.

In accurately describing the services which it provides, the facility makes a major contribution to the patient's need for continuity of care. The scarcity of facilities which furnish a complete range of services places great importance upon interagency cooperation. A dovetailing of services cannot be accomplished effectively unless there is accurate description of services.

In general, even though the facility may feel little pressure to produce a statement of services because it enjoys sufficient income or number of referrals without close community involvement, this does not eliminate the obligation to keep the staff, patients, and other members of the rehabilitation community informed. The patient's re-entry into community life itself requires community organization activity. The facility's public is broadly conceived to include anyone having a relationship with the facility. What was said concerning distribution of information on goals (discussed under the principle in the section on "Goals") is applicable to distribution of the description of services. It is particularly pertinent that the description of services should be adapted to the intended audience.

While the governing body has the responsibility for liaison with the community, this responsibility may be assigned in part to the chief executive, to a public relations staff member, or shared among several parties. Two-way communication is important. Public relations involves more than keeping the facility's public informed of its activities. Pertinent community conditions and developments also must be identified, described and reported to the facility. It is as vital for the facility to be abreast of community developments as it is for the community to be aware of the work of the facility. The person primarily responsible for public relations should be cognizant of key individuals, agencies, and businesses that present information to the public as well as of those who sense and are alert to public opinion.

Evaluation of public relations has two aspects. One is concerned with measuring the impact of public relations efforts by such yardsticks as the variety of media used in releasing news; the results obtained in terms of referrals, contributions, or other benefits; and such additional criteria as may be determined. The second aspect is concerned with the extent to which public relations affect policy making and consideration of new projects. When activities are being reviewed and planned, existing community feelings toward the facility as well as anticipated public reaction to changes in program should be weighed.

Inevitably, despite the most careful public relations efforts of the facility, there will be referrals of patients whose needs are not consistent with the services provided by the facility. When the inconsistency is obvious, a prompt and appropriate redirection of the referral is required.

The provision of services by the facility to each patient should be organized through a patient program manager. This refers to the staff member who is designated to: (1) assume responsibility for the patient during the course of treatment; (2) coordinate the treatment plan; and (3) cultivate the patient's participation in the program. Generally, the staff member representing the service to be primarily administered should assume this role. Thus, a patient primarily in need of medical services will have a physician as his program manager, and a patient primarily in need of vocational services will have a vocational rehabilitation counselor in that role. When the patient's program changes from one major service area to another within the facility, this may require the assignment of a new program manager.

The patient program manager, being responsible for the patient, should see to it that: (1) the patient is adequately oriented; (2) the patient's program proceeds in an appropriate, orderly, purposeful manner; and (3) the discharge decision and arrangements for follow-up are properly made. The management and coordination of services prescribed for patients in a rehabilitation facility can be intensively personal and supportive to the patient, it can be a service which is impersonally provided, or it can leave the patient with no anchor point for his feelings about what is being done to him. In assigning staff members to the role of patient program manager, first consideration should be given to those whose performance would fit into the first category.

STANDARD B.

The rehabilitation facility shall be ultimately responsible for the appropriateness of the patient's program at the facility. Through delegation of authority and responsibility to its professional staff, the facility shall:

1. Establish and follow policies and procedures for intake.
    a. The facility has clearly written criteria for admission.
    b. All referrals for diagnostic evaluation are screened by personal interview, review of application forms, or review of referral information.
    c. Diagnostic evaluation and verification of admitting diagnosis precede initiation of any treatment or training service.
    d. Financial arrangements are fully explained to the patient and/or his family.
    e. Applicants ineligible for service are informed as to the reasons and, if possible, alternative steps are suggested.
2. Establish and follow procedures for evaluation of its patients to determine the patient's program at the facility.
    a. The current diagnosis and report of findings for each patient are available to the professional staff.
    b. The patient's rehabilitation program is established by professional personnel who participated in the evaluation.
3. Establish and follow policies and procedures for orientation of new patients and their families.
    a. Program goals are described to the patient and/or his family.
    b. The services to be provided are explained to the patient and/or his family.
    c. The staff member responsible for the management of the patient's program is introduced to the patient at or shortly after admission.
4. Establish and follow policies and procedures to insure that services required by the program for each patient are provided in an integrated and coordinated manner.
    a. Prescribed services are reviewed for each patient on a scheduling and administrative level.
    b. Appropriate signed notations in the patient's chart validate that patients have received all services to which they have been referred.
    c. Service heads are responsible for making sure that patients receive the treatment prescribed within their units.

d. The patient program manager regularly evaluates the patient's progress and the continuing appropriateness of the program.

e. Staff conferences are held regularly to review the patient's progress, develop further plans, and maintain an integrated and coordinated program.

5. Establish and follow procedures for discharge of patients.

a. The discharge decision and plan is established through the participation of professional personnel from services contributing to the patient's program and other resource personnel as appropriate to the patient's welfare.

b. Discharge authorization and summary are prepared by the patient's program manager.

c. Patient, family, administration of the facility, and referring source are given ample notice concerning the discharge decision.

6. Establish and follow procedures for follow-up of its patients.

a. Arrangements for follow-up contacts are made with the patients, and appropriate individuals or agencies.

b. Follow-up contacts are designed which will support the patient's rehabilitation and which will contribute to evaluating the facility's program.

The facility, although it assigns specific responsibilities to its professional staff, must maintain overall responsibility for the patient's program in the facility. The facility has the discretion of determining which referrals it will accept, in keeping with the goals it has established. For purposes of describing and interpreting this standard, the complete process from referral through follow-up has been divided into seven stages: screening, admission, diagnostic evaluation, treatment services, discharge, and follow-up. The first, or referral, stage consists of the request for service from the patient or by a third party. The referral may be made by telephone, letter, referral form, or the patient appearing in person, but it is not complete until the request for service is presented in a manner approved by the facility.

The second stage is screening. In this process the referral information is reviewed or the patient is interviewed, and the initial determination is made as to his eligibility for diagnostic evaluation or treatment service. There must be at least a preliminary statement of the rehabilitation problem. The screening process should reflect the goals of the facility: if the goals are comprehensive, a committee representing the major service areas should screen referrals for service; otherwise, two or more staff members representing the facility's two or more areas of emphasis determine elegibility for service. This stage also includes explaining financial arrangements to the patient and/or his family, and redirecting applicants to other resources if found ineligible for service.

The third stage is admission. This covers the formal entry of the patient into the program, the notification of appropriate individuals and agencies, the processing of forms, and early orientation procedures.

The fourth stage is diagnostic evaluation. This appraisal is not restricted to medical evaluation; it also includes evaluation of psychological, social, vocational, and educational status. Areas covered in the diagnostic evaluation are determined by the goals of the facility. In this stage, procedures are applied for verifying the admitting diagnosis, and the patient's needs and potentialities are assessed. The outcome of this stage is the decision either to terminate or to develop a treatment plan.

The fifth stage is the treatment service. In its course the treatment plan is developed and followed or modified as required by the patient's progress. This stage is generally the longest; it involves the application of rehabilitation procedures to achieve the goals which have been determined for the individual patient.

The sixth stage is discharge. It begins sufficiently in advance of the actual departure of the patient to satisfy the needs of the rehabilitation plan and extends through confirmation that the planned disposition has been made.

The final stage is follow-up. It extends long enough to obtain maximum gain from the rehabilitation program, and it permits evaluation of the effects of the services.

The first four stages may be considered the intake phase of the rehabilitation program. The less rigorous the intake procedures, the more likelihood there is that individuals may be accepted for service who actually should be referred elsewhere; the greater the degree of vagueness relative to the patient's problems, the greater the possibility of prescribing services which are not germane to the needs of the patient.

Any facility is limited in the number of people it can serve. It is incumbent upon the facility to determine which people it can serve most effectively and to formulate this decision in writing so that a minimum of subjectivity is involved in the process of screening referrals for service. Clearly written admission criteria are not intended to be a substitute for the exercise of clinical judgment in deciding whether or not the program is applicable to the patient's needs; rather, they are intended to conserve the need for such judgments. Written admission criteria are particularly helpful for preliminary screening when the facility limits its services to specified types of disabilities, for example, or has special requirements concerning age, residential location, or financial condition.

Not only to reflect its goals but to assure balanced screening, a facility offering multiple services should include representatives of the major service units on the screening committee. The degree of intensiveness of the screening process will be governed by the degree to which the referral information provides a sound basis for determination of eligibility. If personal interview of the patient is not required in screening, it will generally be required prior to admission to prepare the patient and his family, clarify financial arrangements, and handle miscellaneous details. When an individual has been found to be ineligible for service, the factors involved should be discussed with him, his family, and the referring source, as indicated. The facility should accept responsibility for recommending alternative plans, making referrals as indicated, and, in general, assisting and encouraging the individual to obtain the services he requires.

After the admission of the patient to the program, the facility must verify the referral information through its own evaluation tests and procedures and supplement this information as needed for proper initiation of treatment or training. The facility can be truly responsible for its program and the appropriateness of its services only if every patient has a rehabilitation plan based on an evaluation which the facility is prepared to warrant.

Multidisciplinary involvement is just as necessary for post-admission evaluation and the determination of the patient's program as it is for the screening process. One person can make only a gross evaluation of the full range of patient needs. Therefore, each service provided by the facility should conduct its own evaluation, having available to it beforehand the current diagnosis and referral information. If evaluation findings of a particular service are negative, and the service consequently will not be involved with the patient, the patient's program manager should be notified to that effect. All of the services which will be involved should be represented at a staff conference where their evaluation findings are discussed and the patient's program is decided. Ideally, the decision is based on consensus. If agreement is not reached, the most immediate needs of the patient should be given priority by the patient's program manager. A professional staff of high caliber and a deep sense of dedication, while they may have honest differences, will view the patient's needs with objectivity and discernment; they will not let personal status or exaggerated professional pride influence their recommendations.

The necessity for including the patient as a member of the rehabilitation team is widely accepted. If self-sufficiency of the disabled person is an earnest goal, surely the patient will be encouraged to be independent in all feasible areas as soon as treatment begins. This dictates a full and early orientation program which includes an introduction to the staff and the facility; arrangements concerning fees and other financial matters; and explanation of daily procedures, services available to the patient, the goals of his program, and the nature of his participation. The patient's family or other persons significant in his life should be drawn into the orientation procedure. Treatment in isolation denies reality and closes the door on outside resources which can enrich the rehabilitation program. Considerable reorientation is required to shift the patient's concept of himself from that of a helpless dependent person to one who is active and responsible for much of his program. It will not be accomplished overnight. The contribution of staff members to the orientation procedure—and the role of the patient's program manager in particular—cannot be overemphasized. Not only in words but in their behavior they can demonstrate their acceptance of and respect for the patient.

A patient handbook or brochure incorporating the above considerations is a useful supplement to the orientation program. It should be thorough but not unnecessarily technical, easy to read but not patronizing.

In general, patients should be informed of the goals of their program insofar as their condition permits. In some instances, mental retardation, cerebral dysfunction, or emotional disturbance will limit the patient's ability to understand; in other instances, unrealistically high expectations on the part of the patient will contraindicate immediate exposition of modest program goals. Beyond such limiting factors, there should be full discussion with the patient concerning his program, his participation, and the goals.

A comprehensive rehabilitation plan involves many variables with a high risk of complications, conflicts, distortion, and abridgement. Therefore, appropriate checkpoints, safeguards, and overall supervision are necessary. The objective is to have the patient proceed through his program with a minimum of inconvenience and a maximum of efficiency. Very soon after the formulation of the plan, it should be reviewed on a scheduling administrative level to assure its appropriateness, compatibility, and feasibility. The patient's program manager should have the responsibility for seeing that coordination does, in fact, take place.

Inasmuch as communication among staff is the primary means of coordinating and integrating the program, the opportunities provided for such communication are of critical importance. In small facilities, opportunities for staff communication are almost self-presenting, because staff share offices, lunch together, and have other frequent occasion for contact. In large facilities more formal arrangements are necessary, such as ward rounds in which all disciplines visit patients in a group or chart rounds and staff conferences in which staff review the patients' progress, develop further plans, and continue coordination of efforts. The frequency of such meetings is determined by the needs of the patient and the size and intensity of the program. The patient's program manager must have the cooperation of personnel in all service areas to insure that the prescriptions for treatment of each patient are effectively and completely carried out. Evidence of compliance should be validated through appropriate signed notation in the patient's chart. Service heads are also responsible for making sure that patients receive the treatment prescribed within their units. Staff communication is essential to ensure the continuing appropriateness, efficiency, and effectiveness of the program. The nature and frequency of the communication, be it daily informal telephone conversation or monthly formal staff conference, must be such that it enables meaningful review of the patient's progress and coordination of an appropriate program. There must be evidence that staff communication which meets the above criteria takes place.

The Standards contain a separate statement concerning procedures for discharge of patients. In practice, however, discharge planning should begin early in the treatment phase, and all professions involved with the patient should participate in formulating the discharge plan. This includes agencies outside the facility, such as a family service bureau, who can ease the transition from the rehabilitation facility to the community. The discharge period is particularly critical in that it tends to focus many pressures upon the patient, the facility, and the community. In large measure, discharge presents a test of:

the efficacy of the facility's program; the ability of the service units to work and plan together; the patient's ability to maintain gains that have been made; and the capacity of his family and society to accept him and facilitate his re-entry into the community. It is obvious that the adequate preparation which is needed for discharge requires more than routine notice to the patient that his program is complete. Early and active involvement of the patient, his family, referring source, and other community agencies that will be working with the patient is necessary.

The critical nature of discharge has led some rehabilitation facilities to experiment with trial or interim discharges. These are multiple discharges which take place as the patient progresses through his program, particularly appropriate during plateau periods. It is hoped that through a number of such discharges, the final transition into the community is not as traumatic an experience as the single discharge might be.

Discharge authorization and summary should be prepared by the staff member responsible for the patient's program at the facility. It is also the patient's program manager's responsibility to see to it that reports are transmitted to various agencies so that information pertinent to the needs of the patient is at hand.

Arrangements for follow-up of patients should be made a part of the discharge procedure. The patient as well as the appropriate individuals and agencies should be promptly informed of such arrangements. Follow-up of patients should not be limited to such needs as periodic medical surveillance; it should also determine to what degree the patient's program at the facility has been successful and whether the facility's total program of services offered is adequate. It is through information gathered during follow-up contacts that the facility is able to ascertain if further services are required, and to evaluate the effectiveness of its services and programs. The need for the facility to be flexible and to modify its program can be met best through awareness of the degree to which the patient achieves the goals which had been decided upon.

STANDARD C.

The rehabilitation facility shall maintain responsibility for the appropriateness and professional competence of services when other agencies or nonstaff personnel are required in the patient's program.

The services provided by the facility may require supplementation when unusual developments or complications in treatment occur. In anticipation of such occasions, the facility has the obligation of surveying outside services and selecting those which best meet the needs of the patient in the program. The facility must apply the same yardstick to services which it contracts for or purchases from personnel outside the facility as it applies to personnel and services within the facility. Beyond establishing the fact that outside services are of the same standard of excellence as those of the facility, there is the need to make such services an integral part of the patient's program.

These outside services must be scheduled and provided in such a manner as to coordinate with the program of services provided within the facility. In addition, these outside services must be integrated into the pattern of services within the facility in such a manner as to contribute to the effective functioning of the total rehabilitation team as it concentrates on the specific human needs of the patient within the facility. In instances where conflict may arise because of a patient's desire to be treated by certain outside personnel who in the judgment of the facility do not meet the standards of excellence imposed by the facility, the facility has the duty and the right to refuse to provide such services.

The integration of outside services with the facility program can be greatly assisted by establishing a variety of relationships between the consultants and the facility. Some examples are: inviting consultants to attend or participate in staff training meetings; arranging for consultant demonstration of methods and techniques; and employing consultants to help in program development and research.

STANDARD D.

All professional patient service units of the facility shall have the following characteristics:

1. Patient care
   a. A full range of care as required by the goals of the facility.
   b. Adequate orientation of patients, new employees, volunteers, and others concerning the services.
   c. Diagnostic, evaluative, treatment, and training procedures to the extent which the goals of the facility require and competency of the discipline permits.
   d. Appropriate consultative and educational assistance for the family of each patient concerning his program, progress, and ultimate needs as they relate to the services.
2. Professional
   a. Fulfillment of all professional and legal certification and licensure requirements.
   b. An ongoing evaluation of concepts and techniques utilized by the services in relation to patient progress.
   c. Active participation in rehabilitation conferences concerning patients receiving the services.
   d. Opportunity to recommend patients for any service through the patient program manager.
   e. Fulfillment of professional supervision by designated staff members qualified legally and by training and experience.
3. Administrative

   The facility shall encourage and support professional growth and development through:

a. The conduct of inservice training programs.

b. Ready access to professional reference material relevant to the service and to rehabilitation in general.

c. Provision of opportunities for the conduct of professional education and research.

While professional disciplines vary greatly in their conceptual bases and modalities, they should, in the rehabilitation facility, share a number of characteristics in terms of patient care, professional principles, and administrative procedures.

All professional patient service units should be able to provide the range of care required by the goals of the facility. For example, if the facility includes vocational adjustment among its goals, with no restrictions as to disabilities served, vocational services should include prevocational evaluation, vocational counseling and testing, job tryout, sheltered workshop, vocational training, job placement and follow-up. When intake restrictions justify direct provision of less than the complete range of services, there should be standing arrangements with individuals and/or agencies who can provide supplemental services as needed.

All professional patient service units should contribute to the orientation of patients and their families to the degree to which they, as recipients, are affected by the service provided. New employees should also be oriented to each service unit, as should volunteers and the facility's public.

Each service unit should perform, to the extent professionally qualified, those diagnostic, evaluative, treatment,and training procedures required by the goals of the facility. For example, if personal adjustment is a goal of the facility, patients should be routinely evaluated by a psychologist and/or social worker and/or psychiatrist. Judgment as to diagnosis and treatment then rests with the discipline performing the evaluation, as does the responsibility for providing and coordinating the service. On the other hand, if a psychologist is employed in a facility whose main goal is physical restoration, his role is limited to those services which contribute to physical restoration, such as realistic acceptance of the loss of a limb, psychological adaptation to use of a prosthesis, etc. Physicians may prescribe for physical restorative treatment or therapies within their competence after examining the patient and being satisfied as to the appropriateness of such a prescription. Such services as nursing, occupational and physical therapy, and the fitting of prosthetic and orthotic appliances are provided through medical prescription.

The equivalence among service units with regard to education of families is not meant to imply an autonomous approach. Patients' families often experience a strong need for encouraging information which can lead to a fruitless and disruptive searching. Therefore, while each professional service unit should have equal opportunity to consult with the patient's family upon the latter's request or when the family can be of assistance in furthering the goals of the rehabilitation plan, such activities should be coordinated to avoid duplication or working at cross purposes.

It may be helpful in this discussion of the "professional" section of the standards on "Services" to emphasize that the requirement concerning professional and legal certification refers to service units rather than to personnel. There are an increasing number of professional groups which certify or approve units of service, such as the American Board on Counseling Services, Inc. The list of such standard-setting organizations current at the time of this writing can be found in appendix IV. The facility should meet such requirements as apply to its services. In addition, state and local ordinances must be adhered to, such as licensing as a medical dispensary, sheltered workshop, educational program, and other categories. The facility must determine its legal responsibilities in this area.

Just as the rehabilitation facility engages in self-evaluation through periodic surveys, reviews of goals, and other procedures, so each professional service unit should conduct a conscious, ongoing evaluation of the concepts and techniques it utilizes in relation to patient progress. The staff should have sufficient time to gather and evaluate follow-up information and research data, and apply criteria for a periodic, thorough, self-study. The use of outside consultants to assist in the services' self-evaluation is merited from time to time.

All service units have a responsibility for active participation in rehabilitation case conferences concerning the patients who are receiving their services and the families of those patients. Much of the value of a service is lost if the outcomes of specific treatments are not conveyed to members of the team. While information is imparted through written reports in the patient's chart, the give-and-take of discussion provides a more meaningful exchange of information. Not only is more knowledge gained concerning the effects of the service from different perspectives, but a better understanding of the patient results. Understanding of the patient is a critical factor when personal communication is involved in the application of clinical knowledge. In keeping with the philosophy of interdependent functioning of professional service units, all staff members should have equal opportunity to recommend to the patient's program manager the application of other services that a patient may require.

In the area of administration, each service unit should share several basic characteristics. In-service training programs are necessary for each service unit to maintain staff competency and to provide for growth and development. A variety of techniques should be utilized, such as staff meetings focused upon theoretical concepts or analysis of representative patient programs for instructional purposes, training films, guest speakers, review of literature, etc. In a small unit, an above-average standard would be to arrange meetings with other agencies that have the same service and set up a combined in-service training program.

The specification that each service unit should have access to resource material relevant to rehabilitation in general is based on the assumption that each professional staff member will have a personal collection of basic books and periodicals which he has acquired in his professional studies and to which he adds during his professional lifetime.

However, beyond this, the facility has a responsibility to provide reference material which is especially pertinent to the program and goals of the facility, plus such additional general reference material as is appropriate but may be too expensive for the individual staff member to purchase.

Each service unit has an obligation to its discipline to contribute to the techniques, concepts, and instruction of its field of knowledge. The extent of such contributions is related to the resources of the facility. At the basic level, every practitioner who is alert to his role and relationships in the facility and observes the effects of his efforts is a research worker. More elaborate levels are desirable if major advances are to be made in reducing the gap between the application of services and the scientific basis for the services. Ideally, a coordinated program of research should be established by the facility; the program should be directed by a staff member trained in research methodology and charged with the responsibility for ongoing research.

Because rehabilitation is not a single-discipline approach to the problems resulting from disability, research should not be confined to any one discipline. The coordinator of research should stimulate, assist, and encourage all departments to identify appropriate areas for investigation, develop research designs, and provide statistical or other technical assistance. By relating results to those of other studies and to the professional needs of the staff and the program, the research coordinator can contribute materially to the application and interpretation of findings.

The discussion concerning research is equally applicable to professional education. The rehabilitation facility, ideally, should establish affiliations with universities to provide internship programs for the various disciplines represented in the facility.[5] Internship programs have been increasingly a part of essential training for all professional disciplines. As such, it provides the student with guided, progressive contact with patients in an actual work setting. It also provides the facility with contact with professional training institutions which stimulates and assists the facility staff in keeping abreast of current professional developments. The planning and curriculum of an internship program is customarily developed between the facility and the specific training institution which has agreed to enter into such an arrangement.

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[5] I. P. Robinault, "Professional Education, and Rehabilitation Center Responsibility," New York: Institute for the Crippled and Disabled, 1960.

IV. PERSONNEL

PRINCIPLE:

The staff of the rehabilitation facility shall be competent, professionally ethical, and qualified in the particular phases essential to achievement of the facility's goals. Personnel policies which contribute to the effective functioning of the staff shall be in active operation.

This principle applies to all paid personnel, consultants, and volunteers of the facility who participate in the rehabilitation process. Their combined resources of time, understanding, and skill, coupled with the patient's own efforts, produce restoration and adjustment–thus fulfilling the goals of the facility.

Ideally, all of the relevant physical, mental, emotional, social, educational, and vocational needs of each patient should be considered–both separately and in relation to one another. The successful satisfaction of needs in one area usually hinges upon the satisfaction of needs in other areas. No area is an island; all are interdependent. Only if the special contributions of each staff member are related to the contributions of others can there be an integrated, coordinated approach to the problems and needs of the handicapped, disabled individual.

Personnel policies influence the quality of the staff's contribution to the rehabilitation process. Adequate policies will reflect the basic needs of personnel and foster staff morale. They should result in a smoothly functioning operation and a therapeutic environment based on mutual respect among team members. The patient benefits from both.

STANDARD A.

All facility personnel shall meet the standards of qualification established by the rehabilitation facility.

1. The governing body has final responsibility for standards of qualification for facility personnel. It shall delegate authority and responsibility for implementing standards to the chief executive.
2. All facility personnel shall meet the legal requirements of their positions.
3. When standards of qualification have been established by recognized professional groups, the rehabilitation facility shall adopt these as minimum requirements for its respective professional staff.
4. When standards of qualification have not been established by an organization or group, the measure of competence shall be satisfactory job performance as defined in the job description.

5. **The rehabilitation facility's contractual or consultant services shall meet the standards of qualification established by their respective professional group or organization, by applicable legal requirements, and by such additional evidence of competence as the facility may require.**
6. **Volunteers shall be supervised and have the qualifications required for their assignments. If volunteers provide professional service, they shall meet the standards applied to paid staff.**

The basic activity of a rehabilitation facility is centered in its professional staff. The qualifications which staff bring to their respective positions are fundamental in determining the effectiveness and efficiency of the facility's operations. In establishing standards of qualifications for its staff, the facility is not without legal and professional guidelines. Generally, one's peers are best qualified to define competence. Therefore, when standards of qualification have been established by a recognized national professional organization, they should be considered minimum requirements. Relevant organizations are listed in appendix V. The facility may expand these minimum requirements by adding its own in terms of length or type of experience. The nature of the problems encountered in the evaluation, treatment, and training of the chronically ill often requires skills supplemental to those ordinarily appropriate for serving the transitory ill.

In developing standards of qualification for facility personnel, the chief executive should know the licensure or certification requirements of the state in which the facility is located. He should also consider standards in comparable facilities. Newly created positions which do not have standards of qualification should be clearly outlined in a job description so as to provide an objective basis for evaluating applicants for the position. Once the job description has been tested, amended, and accepted, it provides a basis for comparison with job performance to evaluate the individual's competence. Job descriptions are discussed further on page 34.

Even when a shortage of qualified candidates for employment exists, the facility should not employ an individual who has less than the minimum qualifications unless it is prepared to arrange for the individual to work under the supervision of a qualified person, and to acquire the qualifications necessary for the position within a reasonable period of time. The chronic shortage of qualified professional personnel places an obligation upon all rehabilitation facilities to participate in recruitment activities of a broad nature. In addition to cooperating with agencies and community groups concerned with health career recruitment, rehabilitation facilities can develop work experience programs to provide students with a firsthand, thorough comprehension of health-related occupations, cooperate with schools in career days, sponsor tours, etc.[6]

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[6] The National Health Council, 1790 Broadway, N. Y. 19, sponsors programs in Health Careers Recruitment, and has descriptive material available upon request.

Personnel standards established for employees should not be lowered for contractual, consultant, or volunteer personnel. It is the nature of the task, rather than the class of personnel, which should govern the standards of qualification. Services which are provided by personnel other than employees should be at a level of competence compatible with the facility's rehabilitation effort.

STANDARD B.

The rehabilitation facility shall establish and maintain current personnel policies.

1. **Personnel policies shall:**
   - a. **Be based upon sound personnel management principles.**
   - b. **Be at least equal to established practices in comparable institutions.**
   - c. **Be at least equal to established standards or guides of professional organizations.**
   - d. **Take into account recommendations of the staff.**
   - e. **Be based upon realities of the facility's conditions and the needs of the program.**
2. **Personnel policies shall cover the basic relationships between the employer and employee, the responsibilities and obligations of each, and the general working arrangements.**
3. **Personnel policies shall be a matter of official record and be made available to all staff in an employee handbook or other suitable method.**
4. **Personnel policies shall be reviewed periodically.**

In establishing and maintaining personnel policies, the facility should rely on several contributing sources. The points of general agreement among personnel administration experts provide a foundation on which to build. Greater specificity and focus can be added by appropriately applying the best practices of comparable institutions. The past and current experience of facilities which are similar in goals, size, community setting, and other respects will have demonstrated the merits and faults of various personnel policies.

Because of the close relationship between staff morale and personnel policies, the staff should participate in the formulation of personnel policies. A committee of representatives of the various departments should meet at established intervals to review policies and make recommendations to the chief executive. Some professional organizations, such as the American Occupational Therapy Association and The American Physical Therapy Association, have made recommendations concerning administrative practices and personnel policies.[7] These should also be consulted. Each facility's pattern of resources and goals is unique. For this reason the chief executive must consider many factors in formulating for his facility the most meaningful and appropriate personnel policies.

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[7] See appendix V.

Personnel policies must have an official basis if they are to be effective. They should have general approval of the governing body, with specific details authorized by the chief executive. If they are extracted from minutes of meetings, they should be amplified, clearly written, and complete.

Personnel policies should be included in a staff handbook and given to each staff member as part of his employment orientation program. It cannot be assumed that the personnel within a facility are familiar with the policies simply because they are a matter of public record. The chief executive should establish procedures which insure that staff understand the facility's personnel policies. Employees should always have the opportunity to ask for and receive clarification of any policy.

Personnel policies and procedures should delineate hiring practices, and make clear what the organization expects of staff as well as what staff may expect of the organization; they should establish a frame of reference for dealing with all contingencies related to the activities of personnel within the facility; and they should provide general guidelines for staff conduct. Specific policy requirements will vary considerably among facilities; in the matter of staff conduct, for example, some facilities will find that their programs and patients are best served when relationships between staff and patients are formal and patients are addressed as "Mr." or "Mrs.," or "Miss," while other programs are better served when staff and patients are on a first-name footing and interaction is informal. The subjects which should generally be covered by personnel policies include:

1. Employment procedures
    - a. Authority for hiring and firing.
    - b. Administrative requirements.
    - c. Availability of job descriptions for each position.
2. Operating policies
    - a. Probationary period and periodic evaluation.
    - b. Conduct and general regulations.
    - c. Hours of work, holidays, vacation, leave.
    - d. Laundry and uniforms.
    - e. Promotion policy.
    - f. Grievance procedures.
    - g. Disciplinary action.
    - h. Employee representation.
3. Wages and benefits
    - a. Salary plans.
    - b. Method and period of payment.
    - c. Fringe benefits (insurance, health care, etc.).
    - d. Meals, housing, transportation, etc.

Clearly written job descriptions are essential to effective utilization of staff. Such descriptions guide the staff in the performance of their duties and provide a uniform basis for supervision. "A simple outline which has been found useful for writing job descriptions in social agencies includes: (1) description of the position; what the position is; to whom the person is responsible; (2) duties and responsibilities; (3) qualifications; (4) relationships."[8]

Salary ranges should be established by the facility for each position and each staff member should be informed as to his salary range and the basis for pay raises. Opportunities for advancement to more responsible positions should also be explained.

Each staff member should have the benefit of appropriate supervision of his professional activities. The supervision should be of a quality which contributes to the staff member's occupational and personal development. A formal conference between the supervisor and the member should be held at regular intervals to review job performance. A written summary of the conference or a rating scale should be entered in the personnel file. The importance of a formal conference should not overshadow the more meaningful and instructive approach of evaluation and assistance provided through informal discussions on an ongoing basis. The supervisor also has an obligation to the facility to take corrective action as needed.

To the extent to which changes occur in conditions upon which the personnel policies are based, it is necessary to review established policies. The frequency of review, then, is determined by how often policies and job descriptions need to be changed to keep them appropriate and useful. While the staff committee and other factors described above will make a substantial contribution to the review, much depends upon the degree to which the chief executive is sensitive to and aware of the needs and attitudes of the facility staff. Formal avenues of communication provided by committees will not suffice; they must be supplemented by informal communication and empathy. The morale of the staff will be an index of how successfully the chief executive is maintaining realistic, appropriate, and meaningful personnel policies.

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[8] Ray Johns, op. cit., p. 80.

V. RECORDS AND REPORTS

PRINCIPLE:

The rehabilitation facility shall maintain accurate and complete records and prepare and distribute reports necessary to achieve its goals.

Records and reports are an essential element of professional service, administrative control, and legal responsibility. The extent to which records and reports are developed and maintained is directly related to the quality of services, organizational effectiveness, and accountability of the rehabilitation facility. Records and reports may be divided into two groups–clinical records and administrative records. The former are essential to the care of the patient and, in addition, permit a review of the quality of services and results. Clinical records also are indispensable tools for research and education. Administrative records and reports provide a basis for policy making, program management and control, public relations, and accounting.

STANDARD A.

The rehabilitation facility shall establish, maintain, and utilize clinical records and reporting systems to meet all applicable professional, administrative, and legal requirements.

1. A central patient record for each patient admitted to the facility shall be prepared and maintained so as to communicate clearly, concisely, completely, and promptly.
2. Completed patient records shall include:
   - a. Patient identification data.
   - b. Reports from referring sources.
   - c. Pertinent history, diagnosis, rehabilitation problem, goals, and prognosis.
   - d. Designation of patient's program manager.
   - e. Service referrals.
   - f. Evaluation reports and treatment plan–
     - (1) From each service unit evaluating the patient.
     - (2) From a staff conference of the service units involved.
   - g. Signed clinical and progress reports from each service unit as required by the program plan.
   - h. Reports from outside consultation and from laboratory, radiology, orthotic and prosthetic services, etc.
   - i. Significant correspondence pertinent to the patient.
   - j. Signed patient release forms.
   - k. Record of untoward events.
   - l. Discharge report, including summary statement, disposition, and referral.
   - m. Follow-up reports.
3. Each professional service unit shall maintain a worksheet for each patient receiving services within a unit.

4. Statements of professional judgments or of services provided to a patient shall be signed by the person qualified by professional competency and official position.

5. Patient records shall be maintained on a consistently current basis, with reports of untoward events transmitted immediately and recorded within 24 hours of occurrence, clinical information recorded within 48 hours of the event to be reported, and discharge summaries recorded within two weeks following discharge.

6. Reports based upon patient records shall be authorized by the patient or his legal representative for transmission to individuals and agencies as appropriate to the extent and type of their responsibility for the patient's welfare.

7. Appropriate safeguards shall be applied to protect confidential records and to minimize the possibility of loss or destruction of records.
    a. A registered medical record librarian or other qualified staff member shall be responsible for central patient records.
    b. Access to patient records shall be limited to the professional staff providing direct service to the patient, plus such other individuals as may be administratively authorized.
    c. An appropriate indexing and filing system shall be maintained for all records.
    d. Appropriate controls shall exist so that the location of all patient records will be known at any time.
    e. Records shall be stored under lock, and where there is maximum protection against fire and water damage and other hazards.

8. Records shall be retained for a period of time consistent with professional, administrative, and legal requirements.

The desirable qualities of a patient record are largely self-evident in the terms "clear," "concise," "complete," and "current." Some elaboration of "clear" may be needed because it refers to both technique and substance. The technique of reporting should be such that sentences make sense. The necessity for the reader to attempt to guess what the writer is trying to say defeats the purpose of the communication. Lengthy reports require particular forethought; they should be well-organized and convey the message properly. "Clear," when it refers to the substance of the report means that there should be clear distinction between fact and opinion. Reports should be objective. Information which is subjective should be so designated. It is desirable, generally, to report data by method or source, evaluate the data, and state the conclusions or recommendations which are drawn.

The significance of records and reports has led some recognized national organizations to establish a variety of recommendations concerning their preparation and maintenance. In addition, various states have legal requirements relative to medical and other reports. Such recommendations and requirements constitute minimum standards for clinical records and reports.

A central patient record should be prepared for each patient admitted to the facility. This central patient record should be kept in a central or consolidated file. Each record should include at least the items listed under Standard A-2. Qualitatively, the items listed should substantiate the evaluation and diagnosis, treatment plan, treatment procedures, and discharge decision recommendations.

Patient records are very similar to medical records, with the additional requirements which reflect the interdisciplinary character of rehabilitation: the evaluation report from each service unit evaluating the patient, the treatment plan based on a staff conference of the services involved, and periodic progress reports and re-evaluation.

While all essential data should be located in the central patient record, each professional service unit should maintain worksheets for each patient to record information which is of value only to the specific service, such as daily attendance, raw scores of tests, and similar data. The term "worksheet" is used to emphasize that departmental records should not be a substitute for the central patient record. The central record should receive first priority in the recording of patient information.

The patient's record should include some assurance, in writing, that services recommended and planned for the patient have actually been received by him at the time stated. Such assurances may be in the form of the signature of the staff person rendering the service. The procedure of having a record countersigned by a qualified individual who has an official position in the facility is also necessary to protect the facility in instances where professional judgment expressed in a record may be challenged. Demonstration by the facility that qualified professional individuals are responsible for the content of patient records will help to establish that the facility is providing services based upon high levels of competency.

Because of the wide variety of professional skills focused upon the individual patient in a rehabilitation setting, the effectiveness of the total effort is closely associated with the ability of the professional staff to communicate accurately and appropriately with one another in their day-to-day activities. The appropriateness of the communication has several dimensions, including the method, form, and time. The method of communication ranges from informal verbal messages to legal documents. The form ranges from colloquialisms to technical jargon and symbols. The time varies both in immediacy and in frequency. Obviously, it is impossible to delineate appropriate communication for every activity in the rehabilitation facility. In general, communication should be both prompt and clear, especially in instances of emergency. The proper personnel should be notified immediately when an accident or other untoward event occurs, with the proper form or written summary completed within 24 hours. Information concerning clinical procedures or occurrences should be entered into the record within 48 hours of the event to be reported. Some procedures, such as comprehensive psychological testing, will be exceptions; however, they should be completed and reported before the period when they are of greatest value to the program lapses. Discharge summaries should be recorded within two weeks. Inquiries from other agencies and interested parties should be responded to promptly.

Records instituted in the facility for the patients' care and treatment are the property of the facility. Provision for their use and protection is required. The recordkeeping system should be in the hands of a registered medical record librarian or other staff member who may be qualified as a registered medical record technician by meeting the requirements of the American Association of Medical Record Librarians (see appendix V). Lacking such qualifications, the staff member should at the minimum have attended a recordkeeping institute and have a minimum of one year's experience. Small facilities whose recordkeeping requirements do not warrant a full-time medical record librarian should make arrangements for at least periodic review of the recordkeeping system by a qualified individual.

Access to patient records should be limited to the professional staff providing direct service to the patient, plus such other individuals as may be administratively authorized. Patient records are confidential, representing communication of a privileged nature. Personal information should not be extracted from the patient's record for outside personnel unless there is a signed release by the patient and approval by the chief executive or its release is legally authorized. Unless otherwise legally required, such information should be limited to that which is appropriate to the extent and type of responsibility which outside individuals and other agencies have for the patient's welfare. Impersonal information –such as data to be included in summary reports or research data which does not present identifying information–generally does not require signed patient release.

The usefulness of records should not be negated through haphazard filing and careless storing. Records should be kept in locked metal filing cabinets, or in drawers in a room which can be locked; they should be safe from fire and water damage and other hazards. An indexing and filing system which is efficient and appropriate to the needs of the facility should be maintained. A sign-out system or other means of control should be in effect. The retention of records and reports should be guided by professional, research, administrative, and legal requirements. An appropriate policy should be maintained so that files are not indiscriminately retained nor prematurely discarded.

STANDARD B.

A patient record committee, composed of professional service unit representatives and responsible to the chief executive, shall be established. The committee shall:

1. Regularly review, at least once every 4 months, an appropriate sample of the patient records to measure their adequacy and fulfillment of recordkeeping requirements.
2. Regularly review, in no event less than annually, the policies and procedures concerning patient records and reports, and make recommendations which shall be considered by the chief executive.

The quality of patient records should be judged by the professional services which contribute to the records and use the records. A committee representing the various professional services should meet regularly—at least once every four months. In smaller facilities, all central patient records should be reviewed and measured as to their adequacy and their fulfillment of recordkeeping requirements. The patient record committee should also review at least annually the policies and procedures concerning records and reports, and make recommendations to the chief executive. The chief executive should review all recommendations and discuss their disposition with the committee.

STANDARD C.

The rehabilitation facility shall establish, maintain, and utilize administrative records and reporting systems to meet all applicable administrative and legal requirements.

1. Administrative records and reports shall be developed to guide the operations of the facility, measure and communicate productivity, and reflect the facility's status. They shall include:
   a. Minutes of governing body meetings.
   b. Minutes of administrative and professional staff meetings.
   c. Personnel records.
   d. Fiscal records and reports, including payroll, purchasing, and financial statements.
   e. Statistical records describing the operations of the facility.
   f. Correspondence file.
   g. Safety, fire inspection, public health inspection, and related reports.
2. Appropriate safeguards shall be applied to protect confidential administrative records.
   a. Access to administrative records shall be limited to individuals authorized by the chief executive.
   b. An appropriate filing system shall be maintained.
   c. Appropriate controls shall exist so that the location of all essential records will be known at any time.
   d. Records shall be stored under lock, and where there is maximum protection against fire and water damage and other hazards.
3. Records shall be retained for a period of time consistent with professional, administrative, and legal requirements.

Administrative records and reports are needed to provide control and give direction to the activities of the facility as well as to satisfy legal requirements appropriate to its status. Little is unique to the rehabilitation facility in the development of such reports, other than the description of the facility's operation. Mott has described the dimensions appropriate to reporting the activities of the facility.[9] In outline form, they are as follows:

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[9] Basil J. G. Mott, Basic Accounting Procedures and Cost Accounting, Budgeting, and Statistical Procedures, Chicago: National Society for Crippled Children and Adults, 1960. Chapter IV.

1. Measures of performance

    a. Number of patients treated.
    b. Unit of service provided.
    c. Results obtained.

2. Measures of characteristics of patients

    a. Medical.
    b. Socio-economic.
    c. Demographic.

3. Analyses of financial information

    a. Income.
    b. Expenses.

4. Definitions of productivity on a departmental and individual level

Of particular importance is the annual report which in most instances, is the major source of information about the facility for the public at large. The annual report should clearly state:

1. Objectives of the facility.
2. Nature and extent of the program.
3. Information concerning staff and volunteers.
4. Composition of the governing body.
5. Community and interagency relations.
6. Financial status.

Standards pertaining to these areas have been developed by the National Health Council.[10]

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[10] National Health Council, Accounting and Financial Reporting Procedures for Voluntary Health Agencies, New York: Chapter V.

VI. FISCAL MANAGEMENT

PRINCIPLE:

The fiscal affairs of the rehabilitation facility shall be soundly managed and legally proper.

The very existence of the rehabilitation facility depends on its financial viability. Unless its fiscal affairs are soundly managed the facility will not be able to stay afloat, much less to guarantee services in keeping with its goals. Fundamentally the fiscal management of the rehabilitation facility does not differ greatly from that of any business organization. Basic requirements are: (1) efficient and effective recording, reporting and control of earnings, expenses, assets, and liabilities; (2) collection and reporting of statistical data; (3) determination of costs of services and activities, some of which are unique to rehabilitation; and (4) preparation of budgets. To assure soundness of method, professionally acceptable accounting practices should be employed. Legal requirements must be met, and should be exceeded wherever superior fiscal management will result.

STANDARD A.

The financial operations of the facility shall conform to legal requirements, and be based upon sound financial planning and prudent management of capital, operating income, and expenditures.

1. Accounting practices which are in accordance with generally accepted accounting procedures appropriate to the facility shall be employed.
2. The facility shall operate on an annual budget. The budget shall:
   a. Reflect and anticipate the facility's needs and resources in realizing its goals.
   b. Be submitted to and approved by the governing body.
   c. Be used, during the year covered, as a yardstick to assess accomplishment of budgetary goals.
3. The financial operations of the facility shall be audited annually and fully attested to by a qualified accountant–preferably by a certified public accountant independent of the facility–and submitted to the governing body.
4. Fiscal reports shall be prepared and communicated to the governing body at no less than quarterly intervals, and additionally as needed.
5. Fiscal reports shall be prepared and communicated to the facility's public at least annually.

The legal requirements concerning the conduct of business vary from state to state; they constitute minimum levels of operation. The rehabilitation facility should stipulate additional requirements as indicated for superior fiscal management. The use of professionally acceptable accounting practices is essential. Several systems of accounting have been described elsewhere.[11] It is expected that whatever system is adopted will be based on the needs of the facility and that the simplicity or complexity of the system will be related to the degree of control required.

The annual budget is an instrument used to analyze past accomplishments, control present operations, and guide program development and planning. The factors involved in preparation of the budget have been described elsewhere.[12] Essentially, the budget should reflect and anticipate the facility's needs and resources as they relate to the realizations of its goals. The preparation of the budget should involve the active participation of the department chiefs. The governing body must approve the master budget. As a tool, the budget should not be used in a completely rigid, nonadaptive manner. If unanticipated factors develop, major budgetary modifications should be submitted to the governing body for approval. However, the greater the departure from the original budget, the less useful the budget is as a controlling device. Periodic comparison of the budget as formulated with the actual income and expenditures provides a means of measuring ongoing facility performance.

The financial operations of the facility should be audited annually by a qualified accountant or recognized accounting firm in good standing in the accounting profession. Preferably, a certified public accountant should conduct the audit. To help assure impartiality, the accountant should not be on the staff of the facility. In governmental facilities a unit of the government may conduct the audit, but in such instances the accountant should be administratively independent of the facility.

Fiscal reports will require transmittal and presentation to various groups, according to the nature and obligations of the facility. Examples are the governing body, community fund budget review committees, professional organizations, and the general public. The frequency of such reports will vary according to the size and other characteristics of the facility, but should not be less than quarterly for the governing body nor annually for other groups. Reports should be presented in such a manner that they clearly and accurately reflect the operations which are being fiscally analyzed, and do so in relation to the program's goals.

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[11] Basil J. F. Mott, Basic Accounting Procedures and Cost Accounting, Budgeting and Statistical Procedures, Chicago: National Society for Crippled Children and Adults, 1960.
American Hospital Association, Bookkeeping Procedures and Business Practices for Small Hospitals, Chicago: 1956.

[12] T. S. Allegrezza, "Financial Structure and Budgeting," in The Planning of Rehabilitation Centers, Washington, D.C.: U. S. Department of Health, Education, and Welfare, 1957.

STANDARD B.

The facility has the responsibility for maintaining its financial solvency through such means as setting and collecting fees, and obtaining endowments or other private or public support.

1. **The facility's schedule of fees shall be based upon adequate knowledge of the costs of its services.**
2. **The facility's schedule of fees shall be available in printed form to the facility's public.**
3. **The facility's schedule of fees shall be applied to each patient fairly and equitably.**
4. **The facility shall not split fees with other agencies or individuals as consideration for referral of patients.**

Regardless of the type of ownership, financial solvency is an obligation which cannot be neglected unless the facility is to discontinue operation. Even governmental facilities must demonstrate financial responsibility or risk a reduction or cessation of public support. As a matter of principle, heavily endowed facilities or those with ample sources of income are responsible for economical and efficient use of funds in carrying out their objectives. On the other hand, facilities in straitened financial circumstances are not justified in using this condition as an excuse for applying shortcuts which result in a below-standard program. It is better to eliminate a service and reduce the goals of the facility than to stretch resources to the point of inadequate coverage. The facility has a responsibility for setting and collecting fees in order to stay in operation, as long as its rehabilitation goals are being met.[13] After the schedule of fees required for financial solvency has been determined on a sound accounting basis, there should also be evidence that the facility has considered the effect of its actions upon its moral obligation to extend its services to as many persons as it reasonably can. In particular, some provision should be made for those, who, because of limited means, are not otherwise able to receive service. The facility should seek some resource, such as private or public financial support, to make up the difference between the fees incurred and the patient's ability to pay. This does not necessarily require that the facility conduct a fund drive, but rather that there be effective utilization of community agencies and other sources of support for the facility's program.

The referral of patients for services should be guided primarily by the rehabilitation needs of the patients, rather than the financial reward to the agencies involved. It is therefore improper for the facility to split fees with other agencies or individuals as a consideration for referral of patients. The decision as to where the patient is referred should be directly related to such criteria as determine which resource best meets the patient's rehabilitation needs.

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[13] Frederick Weiner, "Experimental Fee Structure Based on Direct Cost of Service," American Personnel and Guidance Journal, 1963, 61 (5) 448-449.

STANDARD C.

Fund raising activities of the facility shall conform to the Standards of Fund Raising Practices for Social Welfare Organizations, established by the National Social Welfare Assembly.

When the facility engages in fund raising, it should adhere to the standards set forth in the "Standards of Fund Raising Practices for Social Welfare Organizations."[14] All fund raising campaigns and activities should truthfully represent the objectives, program, and performance of the facility, and must be ethically conducted.

STANDARD D.

The facility shall have an adequate risk protection program to preserve the assets of the facility and to provide reasonable compensation for the staff, volunteers, patients, and the public as may be required for untoward events for which the facility is financially liable. There shall be at least annual review and evaluation of the needs for insurance and the types of protection offered.

The variation of insurance requirements from state to state requires each rehabilitation facility to be in contact with the State Insurance Commissioner concerning workmen's compensation, malpractice, and other types of insurance applicable to the facility. As in the instance of other legal requirements, these constitute minimum standards, and it is the responsibility of the facility to develop a risk protection program adequate for the preservation of the assets of the facility and for the reasonable compensation of the staff, volunteers, patients, and the public who may be casualties in situations for which the facility is financially liable. The risk protection program of the facility should be reviewed at least annually by the chief executive and a qualified adviser to make sure that the policies carried provide the amounts and types of protection needed. The adequacy of the risk protection program is the ultimate responsibility of the governing body.

STANDARD E.

When the facility operates a sheltered workshop, it shall conform to applicable legal requirements and sound business practices compatible with its goals.

1. **The workshop shall hold a sheltered workshop certificate from the Wage, Hour, and Public Contracts Division of the U.S. Department of Labor, unless it is a governmental unit.**
2. **The workshop shall avoid unfair competition with other workshops and/or commercial organizations in selling its services and products.**

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[14] National Social Welfare Assembly, Inc., 345 East 46th Street, New York, N. Y.

3. **The wages paid in extended employment sheltered workshops shall correspond with those which are paid for comparable levels of productivity in private industry.**
4. **Capital expenditures and other nonproduction costs shall be financed by sources other than the direct results of patients' work.**
5. **The workshop shall have a business manager who has a background in business procedures, concepts, and techniques of bidding and who shall be responsible to the workshop supervisor.**

When the facility operates a sheltered workshop, appropriate legal requirements and sound business practices compatible with its goals should constitute the minimum standard. Except in the case of governmental units, all sheltered workshops must hold a sheltered workshop certificate from the Wage, Hour, and Public Contracts Division of the U.S. Department of Labor. In addition to meeting all federal and state wage and hour regulations, all workshops should strive to exceed minimum standards. Government-sponsored workshops should not use their exemption as a means of avoiding their obligation to meet prescribed standards for payment of wages.

The workshop should not engage in unfair competition with other workshops and/or commercial organizations in selling its services and products. As in the rehabilitation of the disabled individual, the workshop should build its program on the basis of its strengths rather than ask for special consideration because of its handicaps. The practice of undercutting the bids of other organizations at the expense of work that is below specifications is unethical and self-defeating. In communities where a large proportion of the labor force is unionized, it would be well for the workshop manager to establish good relationships by providing unions with an understanding of the principle and goals of the sheltered workshop.

For purposes of discussion concerning remuneration of patients in sheltered workshops, a distinction may be made between the extended employment workshop which offers long-term work to handicapped individuals and the transitional workshop which concentrates on evaluation and therapeutic services. In the former, the remuneration should be commensurate with the productivity of the patients at the rate established by local private industry. Such professional services as are provided in these programs should be financed by sources other than the patient's production. The patient should receive what he earns, less direct production costs.

In the transitional sheltered workshop, the patient should be paid at a level commensurate with developing and maintaining the motivation appropriate to the goals of the workshop, and in no event less than legally permitted.

VII. PHYSICAL PLANT

PRINCIPLE:

The physical plant of the rehabilitation facility shall be such that its size, location, and construction promote the fulfillment of its goals and protect the safety of its clientele and personnel.

"Physical plant" refers to the physical structure, its location, and its equipment. The physical setting of the rehabilitation facility is determined in relation to all other elements: institutional goals, organizational structure, clientele, personnel, and services. It is the material property, the identifiable spatial unit in which rehabilitation treatment and training of the handicapped, disabled individual takes place. It houses personnel and equipment and is designed to effect optimum restoration and adjustment of the individual patient in accordance with his problems and needs.

STANDARD A.

The physical plant and equipment of the rehabilitation facility shall meet all applicable legal requirements for construction, safety, and design.

It need hardly be emphasized that rehabilitation facilities must conform to all laws—federal, state, and local—which relate to them directly. With respect to "physical plant and equipment," this means conforming to health department requirements, safety regulations, building codes, zoning ordinances, and other legal acts which pertain to construction, safety, and design. In short, if the law is there, the rehabilitation facility must obey it unless there is sound justification for seeking legal exemption.

In addition to the obvious legalistic conformity required of the rehabilitation facility, there is a moral obligation for it to conform to statutes which are permissive in nature, but which suggest desirable standards of construction, safety, and design. The rehabilitation facility should exceed minimum legal sanctions in matters significantly related to the success of the program and the welfare of the patients.[15]

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[15] A basic reference to construction specifications is, American Standards Association, American Standard Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped. National Society for Crippled Children and Adults, Inc., Chicago, Ill. 1961. A complete bibliography is available from the U. S. Department of Health, Education, and Welfare, Selected References on Design of Facilities for Long-term Patients, U. S. Government Printing Office, Washington, D. C. 20402. October 1963.

STANDARD B.

The physical plant and equipment of the rehabilitation facility shall meet recognized standards required for each professional service.

1. **The staff shall be consulted concerning need for equipment, selection of equipment, or modification of facilities used in the conduct of the program. (In the case of a new facility which has not yet acquired staff, individuals qualified by training and experience shall be consulted.)**
2. **The requirements for safety, welfare, and insofar as possible, the convenience of the patients shall be met in the construction and maintenance of the physical plant and the equipment.**
   - **a. Written plans and regulations covering disaster, evacuation, and safety measures shall be made available to all staff personnel.**
   - **b. Emergency fire drills shall be held at four-month intervals, as a minimum.**

Some recognized professional organizations have established standards for physical plant and equipment—just as they have for personnel qualifications and for records and reports. Where these standards are relevant, they should be accepted as minimum requirements. Ultimate responsibility for determining standards and providing proper physical facilities for a professional service rests with the governing body and the chief executive, but their decisions should be based on the best advice obtainable from qualified representatives of the respective professions. The practicing expert—better than anyone else—knows what he needs to help him do a good job. The governing body should recognize that any person involved in the application of a professional service has an obligation to the patient to refuse to apply that service if the application must take place under conditions which are demonstrably adverse to the health, welfare, and safety of the patient.

The professional staff of the rehabilitation facility should participate in the periodic review of needs associated with physical plant and equipment. This review should assess those needs as they relate to the basic pattern of integration and coordination of services within the facility, and not as they relate to isolated service functions. The physical plant and its equipment should be viewed as a mechanism for bringing together diverse professional specialties for the application of a program to a person in need of being rehabilitated. To the degree that the physical surroundings reinforce this focusing of services on the individual patient, they are efficiently supporting the rehabilitation concept.

In addition to meeting legal and professional requirements, the physical plant of a rehabilitation facility should be designed primarily to meet the unique needs of disabled, handicapped individuals. Barriers to the patient's self-care should be eliminated insofar as possible. The general atmosphere should engender a feeling of vitality. In other words, the setting should contribute to a therapeutic environment. Many individuals live a significant portion of their lives in a rehabilitation facility. It is essential that their surroundings be not only physically comfortable but psychologically and aesthetically appropriate. When plans for a new facility are being made, it would be well to survey the patients of a similar facility to get their ideas and recommendations.

While professional services are central to the operation of a rehabilitation facility, much that takes place within its walls does not relate directly to professional activity. Such factors as accessibility, ventilation, heat, light, cheerful and functional interior decoration, cleanliness, sanitation, personal convenience, and many other factors are indirectly yet significantly involved in the proper application of services.[16] Related standards and their application should be the responsibility of the chief executive or his designate. In all instances the person or persons who must make judgments relative to convenience and welfare should seek the best advice obtainable. Lines of communication with the personnel involved in tasks associated with these minimum standards should be kept as open as possible. Practical suggestions for improving convenience and welfare often originate with them.

Emergency plans should cover all types of possibilities from natural disasters to manmade catastrophies. They should be coordinated with community and state efforts. A designated staff member should be responsible for keeping the facility's plans up to date and for keeping the staff and patients informed of and prepared for emergency procedures.[17]

Emergency fire drills should be conducted at least three times annually. If the facility has more than one shift of employees, this applies to all shifts. Patients need not be involved in the drill, but the kinds of difficulties presented in the evacuation of patients with various disabilities should be included in the drills to provide the staff with the preparation necessary for an actual emergency event.

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[16] Specifications for each of these factors are presented in the Survey Form for Rehabilitation Centers and Facilities.

[17] American Hospital Association, Principles of Disaster Planning for Hospitals, Chicago: 1956.

APPENDIX I.

INDIVIDUAL AND FACILITY PARTICIPANTS

An undertaking of the size and scope of this project would have had minor results and and significance were it not for the assistance and cooperation of many individuals and organizations. The ARC Research Committee, listed on page iii, had overall policy direction for the project and final responsibility for recommendation of the standards material to the rehabilitation community.

Adviser-consultants were appointed early in the study to establish close communication with the basic professional disciplines represented in rehabilitation facilities. Together, the adviser-consultants served as members of a multidisciplinary committee to advise the project staff on all phases of the study. In this capacity, the advisers helped synthesize the recommendations of professional groups and provide overall balance and perspective to the material as it was developed. Individually, each adviser-consultant served as the chairman of a subcommittee. The original subcommittee reports are reproduced in appendix II. The members of the committee of adviser-consultants are listed below.*

Leonard Diller, Ph.D.	(Psychological Services)
Oscar Kurren, M.S.W.	(Social Work Services)
Frank M. Lassman, Ph.D.	(Speech and Hearing Services)
Basil J. F. Mott	(Management Services)
C. Esco Obermann, Ph.D.	(Vocational Services)
James W. Rae, Jr., M.D.	(Medical Services)

Eleven rehabilitation facilities were asked to participate in the Standards Project to provide a testing ground for critical evaluation of the standards and a source of information to describe exemplary practices.

The facilities were selected on the basis of two factors: (1) established reputation as outstanding rehabilitation facilities; and (2) diversity in size, type of program, administrative setting, and location. The administration and staff of the facilities were unfailingly helpful in the study. The participating facilities were:

Institute for the Crippled and Disabled
New York, New York

Institute of Physical Medicine and Rehabilitation
Peoria, Illinois

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* Professional affiliations are listed for these individuals in their respective subcommittee reports.

Kaiser Foundation Rehabilitation Center
Vallejo, California

Kenny Rehabilitation Institute
Minneapolis, Minnesota

Minneapolis Rehabilitation Center
Minneapolis, Minnesota

The Ohio Rehabilitation Center
Columbus, Ohio

Pennsylvania Rehabilitation Center
Johnstown, Pennsylvania

Rehabilitation Department, Jewish Hospital
St. Louis, Missouri

G. F. Strong Rehabilitation Centre
Vancouver, B.C., Canada

Texas Institute for Rehabilitation and Research
Houston, Texas

Younker Memorial Rehabilitation Center
Des Moines, Iowa

APPENDIX II.

PROFESSIONAL SERVICES SUBCOMMITTEE REPORTS

The seven professional service subcommittees, whose chairmen are listed in appendix I, were established to provide: (1) liaison with the basic professional groups to be found in rehabilitation facilities; and (2) source material for the development of standards for rehabilitation facilities. The original reports of the subcommittees, with the exception of speech and hearing,* are reporduced here as additional background material for the standards and to provide a more detailed analysis of each professional service than was incorporated into the broader treatment of facility programs.

In the development of the standards, the reports which follow and other source documents were reviewed and evaluated by project staff, adviser-consultants, and Research Committee; appropriate material was accepted or modified for field testing, and revisions made as indicated for final acceptance by the Research Committee. Although many of the recommendations in the following reports are based on previous studies and clinical experience, not all were tested for application in rehabilitation programs and cannot, therefore, be endorsed in their entirety.

MANAGEMENT SERVICES SUBCOMMITTEE REPORT

Chairman: Basil J. F. Mott, Associate Professor
Div. of Public Health Practice
School of Public Health and Administrative Medicine
Columbia University
New York, New York

Bertram J. Black, Executive Director
Altro Health and Rehabilitation Services
New York, New York

William K. Page, Executive Director
Kessler Institute for Rehabilitation
West Orange, New Jersey

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* The speech and hearing report is not included as the subcommittee did not complete its assignment. Information about standards in this area can be obtained from the American Speech and Hearing Association, 1001 Connecticut Ave., N. W., Washington, D.C. 20006.

Margaret E. Peters, Administrator
Institute of Physical Medicine and Rehabilitation
New York University Medical Center
New York, New York

Charles L. Roberts, Administrator
Pennsylvania Rehabilitation Center
Johnstown, Pennsylvania

I. GOALS

A. A rehabilitation center shall have goals that govern the direction and character of its program. The goals shall specify:

1. Its rehabilitation objectives in serving patients. For example, the rehabilitation of orthopedically disabled pre-school children for admission to school.
2. The program it has established to achieve these goals.
3. Whom it will serve, such as types of disabilities accepted, and age, sectarian, and other limitations.

B. The goals of the center shall be central to its operation and fully described for the general public, third parties and referring groups, and for its patients. To this end, they shall be reflected in the center's publicity, reports, and policies and procedures.

C. The goals of the center shall be reviewed regularly by its trustees and responsible administrative staff. Such review shall be made at least annually and the general public, referring sources, third-party agencies, and the patients shall be kept abreast of any modification of center policies within reasonable time.

D. The center's goals shall be consistent with its charter. If the goals and charter are found to be not consistent, the charter shall be revised to reflect the goals or the goals changed to meet the general conditions of the charter.

II. ORGANIZATION

A. A rehabilitation center shall be incorporated in accordance with applicable state and federal laws, unless it is part of another organization. If it is part of another organization, the parent institution shall be properly so incorporated. This provision is applicable to governmental rehabilitation centers only as appropriate.

B. The center shall observe all laws and governmental regulations applicable to its operation.

C. The administrative head of the center and other staff members shall not be members of the board of directors, except when it is fully justified on an ex officio basis, so as to avoid any potential conflict between their role as staff and as trustees. The constitution and bylaws of the center shall define the composition, organization, and function of the board and all standing committees.

D. If it is a private agency, the board of directors of the center shall be recognized and function as the final voice of responsibility and authority of the center, unless the center is part of another organization, in which case the board of directors of the parent organization shall be such final voice.

E. If a governmental agency, the highest authority to which the center is responsible shall be recognized and function as the final voice of responsibility and authority of the center.

F. The board of trustees (or other authority as defined above) shall be responsible for engaging such personnel as are required to carry out the goals of the center. In fulfilling this responsibility, the board shall appoint an administrative head who is responsible to it, to whom is given full authority for planning and executing a center program designed to fulfill all goals of the center, and to whom all staff is responsible. It should be recognized that the authority of the administrative head is derived from the nature of his responsibilities to the board, rather than from his individual qualifications.

G. The center shall have a statement of and an organization chart describing its organization and the function of its departments and other units, including all interdepartmental and other committees.

H. Function of all committees shall be carefully defined so they will not conflict with individual staff responsibilities or cause duplication of efforts or cross purposes.

I. Advisory committees of the center shall not make or execute policy. They may recommend policy and procedural changes, as in the case of a medical advisory committee, but proposed policies must be set and approved by the board of directors in order to become effective.

J. A major responsibility of a center is to inform the public, including patients, referring groups, and third parties, of its role in the community, including its objectives, services, and performance. The entire staff has ongoing responsibility for carrying out the public relations obligations of the center, by virtue of group loyalty, and understanding of the center's basic goals and program objectives. The presentation of the center's objectives, program, and performance to the public shall be truthful. This applies to all verbal communications as well as written materials.

III. SERVICES

A. The center shall provide or have available to it the services needed to attain the goals that it has established. (Determination of the kinds of services required to meet particular rehabilitation goals is a question to be answered by the other subcommittees of the Standards Project). The center shall obtain the advice needed to determine what services are essential to meet its goals and to determine the competence and qualifications required of staff to provide these services.

B. The center shall have an admission policy and an implementing procedure which establish clear criteria for admission. Such criteria shall be derived from the center's goals and serve to implement them. The admissions policy and procedure shall be in writing and shall provide full explanation to entering patients of:

1. The goals of the center in serving them, as outlined above.
2. How they will be served.
3. Who they can officially turn to for advice and counsel about their problems and life at the center.
4. The rate of charge.
5. The basis on which they will be charged. For example, whether they are entitled to some type of third-party support (e.g., workmen's compensation, Blue Cross, etc.) or will be granted reduced rates or free service.

C. The center has final responsibility for the patient's program at the center. This includes decisions as to the professional soundness of the admitting diagnosis, prescription, and course of treatment. Acceptance or professional review of the diagnosis and prescription provided by the referring source is the responsibility of the center and acceptance of any patients for service within the center must be consistent with the goals of the center. Final determination of the patient's diagnosis, prescription, and course of treatment, or acceptance of the diagnosis and prescription of referring sources, must be made by competent professional personnel subject to the authority of the center. In the case of medical aspects, such personnel shall be duly recognized and licensed to practice medicine.

D. The center shall establish policies and procedures for evaluation of its patients and determination of the program. These should provide for collection of all of the relevant data from referring and other sources and review of such outside information about each patient.

E. If services of other agencies or nonstaff members are used by the center in serving the patient, the center shall retain responsibility for the appropriateness and professional competence of such service. They shall meet the standards established by the center for its own services and be consistent with the goals of the center and individual program of the patient. They also shall be related to and integrated with the services given at the center.

F. The center shall have an active philosophy of encouraging interest in the program and progress of the patient by the referring source, the family and friends, and all those who might contribute to his rehabilitation. Their participation in estimation and review of the patient's program shall be encouraged insofar as it is in the patient's best interests. The center also shall keep the referring source adequately informed of the program and the progress of the patient.

G. The center shall establish policies and procedures to coordinate the services received by the patient to insure that evaluation and treatment are effectively directed toward the goals established for him. Provision shall be made for scheduled re-evaluation of each case to assess progress of the patient toward the goals and to determine his need for possible new plans or procedures.

H. The center shall assign to each patient a member of the staff who shall be responsible for communicating with the patient and seeing that all of the patient's needs are understood and considered in the determination and execution of the patient's program. The patient shall be told at the time of admission or promptly thereafter who this person is with whom he may counsel and communicate at all times.

I. The center shall establish policies and procedures to insure that all patients receive the services that have been prescribed for them. These should include provision for recording in the patients' records the services given and controls to see that the patients are properly scheduled and actually receive services for which they are scheduled.

J. The center shall establish discharge and follow-up policies and procedures that clearly define criteria for discharge and follow-up. They should provide for adequate preplanning to assure that the patient, his family, and others in his community are adequately briefed concerning their responsibilities to him. The patient should be informed of any other agencies or groups whose services he may need to continue his progress or maintain his gains. Necessary referrals to other agencies should be made before discharge. Referring sources such as the family physician and third-party agencies should be properly informed of the patient's discharge and continuing program needs. The center is also responsible, for a reasonable time after discharge, for maintaining contact with the patient and for ascertaining whether the patient is progressing or is maintaining his gains.

IV. PERSONNEL

A. The basic qualifications of the administrative head of the center shall be an educated person with experience and personal qualifications for direction of a rehabilitation. Minimum standards shall be a bachelors degree or its equivalent, prior administrative experience including the supervision of other people, and some experience in a health or welfare organization.

B. The center shall have an up-to-date staffing table, showing the number and the types of positions which are currently determined to be required to man its organizational units and effectively realize its goals within the financial resources available to it.

C. The center shall establish personnel policies and procedures covering:

1. Professional and other qualifications required of incumbents for each position.
2. Minimum and maximum salary for each position and promotion steps.
3. Holidays, sick leave, vacation, retirement, etc., to which the employees are entitled.
4. Hiring and firing process, including periods of probation, trial, etc.
5. Presentation of employee grievances and review and appeal of personnel actions which the employee wishes reconsidered.

D. The center's volunteers shall meet all of the professional and other requirements of the positions in which they are used. They also shall be fully oriented to their positions. When used in nonprofessional positions in departments serving patients, their work shall be supplemental to that of other staff and only in the best interests of the patients or clients. The work of volunteers shall be consistent with the responsibilities of regular staff. Volunteers shall always be under the supervision of the departments or units of the center in which they work. Periodic review and evaluation of volunteer services should be made in order to measure and determine the efficacy and value to the patient and to the center of such services.

E. The center shall have complete financial, legal, and insurance advice available to it at all times. Advisers may be members of the board, but preferably not, in order to avoid any possible conflict of interest. They shall not be staff members, unless retained only for these purposes. Adviser roles may be combined, provided the persons so chosen are competent to perform all aspects.

V. RECORDS AND REPORTS

A. The records of the center shall be related to its particular needs.

B. The center shall review, at least annually, all of its policies and procedures pertaining to records to insure their adequacy and efficiency and to insure appropriate retirement or destruction of old records periodically.

C. The center shall prepare accurate and adequate records of all meetings of the board of directors and of major staff meetings, and give appropriate circulation to these records. In particular, policy decisions and other major administrative actions shall be recorded and disseminated.

D. Patient records shall be consistent with the fullest needs of the patient, shall meet the needs of the center in realizing its goals, and shall be completed in accordance with professional standards for such records. All professional and legal requirements, such as confidentiality and proper signature, shall be carefully observed. (Reference: Joint Commission on Accreditation of Hospitals.)

E. The center shall prepare an annual report covering program activities and financial position as well as other appropriate subjects.

F. The center shall prepare for the administration and trustees frequent periodic reports of operations, including program and financial performance, using statistical and other techniques of measurement and analysis. Such reports shall be prepared at least semi-annually, preferably quarterly or more frequently, according to the needs of the center. (Reference: Cost Accounting, Budgeting, and Statistical Procedures for Rehabilitation Centers and Facilities, Basil J. F. Mott, et al., 1960.)

VI. FISCAL MANAGEMENT

A. The system of accounting shall be adequate to the needs of the center and shall be based on sound principles of accounting. (Reference: Basic Accounting Procedures for Rehabilitation Centers and Facilities, and Cost Accounting, Budgeting, and Statistical Procedures for Rehabilitation Centers and Facilities, Basil J. F. Mott, et al., 1960.)

B. The financial operations of the center shall be audited annually, and fully attested to by a recognized public accounting firm in good standing in the profession.

C. The center shall, through preparation of a budget, plan its program for each subsequent year. The center's needs in realizing its goals shall be anticipated and reflected in the budget. (Reference: Cost Accounting and Statistical Reporting for Rehabilitation Centers and Facilities, Basil J. F. Mott, et al., 1960.)

D. The center shall use the budget, during the year covered, as a yardstick to measure and assess actual, ongoing performance by comparing the budget regularly with actual performance.

E. The scope and details of the center's budgeting shall be clearly related to its needs.

F. Supply and Procurement

1. The center shall establish policies and procedures that provide for:

    a. Utilization of competitive conditions in the market to achieve maximum economy consistent with quality of services, supplies, and equipment required.
    b. Regular review of vendors.
    c. Regular review of pricing.

2. Internal controls shall be established to insure against unethical practices and conflict of interest in purchasing.

G. Fund Raising

1. Fund raising is a primary responsibility of the board of directors of the center. Responsibility for fund raising campaigns may, in part, be delegated to the administrator, but other staff shall not be required to participate in such campaigns unless they are retained or volunteer expressly for them.

2. All fund raising campaigns and activities shall truthfully represent the objectives, program, and performance of the center and shall be ethically conducted.

H. Fees for Service

1. The decision whether and how much to charge for its services essentially is a responsibility of each center. However, a center has a responsibility for setting and collecting fees for service if endowment or other private or public support is not adequate to accomplish its objectives.

2. In determining fees for service, the center also has a responsibility to consider the effect of any or all of its actions on its moral obligation to extend its services to as many persons as it reasonably can, especially to those who, because of limited means, would not otherwise be able to receive service.

3. The application to each case of the center's schedule of fees for service shall be fair and equitable, and shall be related to the patient's ability or inability to pay (including third-party support) and to the center's ability to provide the services needed.

4. In establishing a schedule of fees for service, the center shall have adequate knowledge of the costs of its services, based upon sound principles of accounting, and adequate knowledge of the relationship between its total operating cost.

I. Restricted Funds

1. The center's use of funds that have been received with conditions shall be strictly in accordance with the conditions and wishes of the grantor or contributor.

2. To insure proper use and to provide a sound basis for reporting, adequate records shall be kept of the use of all restricted funds.

VII. PHYSICAL PLANT

A. The center shall make full use of professional advice (state and local agencies, university, etc.) in the management of its plant and property in order to protect and promote its best interests. (Reference: American Hospital Association manuals on Maintenance and on Insurance.)

B. The center shall establish a safety committee to provide for disaster planning, fire protection and evacuation, safety education, and similar matters.

C. The center shall provide for adequate insurance to protect the plant and property, regular staff, volunteers, patients, and the public from all serious risks in carrying out the program. There shall be regular review and evaluation of any and all needs for insurance and of the types of protection offered. This is particularly important in view of the vanishing immunity from suits of nonprofit organizations.

D. The management of the plant and property shall be consistent with state and federal laws and regulations applicable to the center.

MEDICAL SERVICES SUBCOMMITTEE REPORT (PHYSICIANS)

Chairman: James W. Rae, Jr., M.D., Chairman
Department of Physical Medicine and Rehabilitation
University of Michigan Hospital
Ann Arbor, Michigan

Paul M. Ellwood, Jr., M.D., Executive Director
American Rehabilitation Foundation
Minneapolis, Minnesota

Thomas Gucker III, M.D., Director of Rehabilitation
Orthopedic Hospital
Los Angeles, California

Justus B. Lehmann, M.D., Executive Officer
Department of Physical Medicine and Rehabilitation
University Hospital
University of Washington Medical School
Seattle, Washington

Donal R. Sparkman, M.D., Medical Director
Division of Vocational Rehabilitation
State Board of Education
State of Washington
Olympia, Washington

I. MEDICAL SERVICE GOALS

The goals of a medical service within a rehabilitation center, in full accord with the stated goals of the institution itself, shall specify:

A. The full range and type of patients to be served.

B. The rehabilitation objectives incorporated in the program of services for patients.

C. Specific limitations, clearly defining the extent of services available and those not provided at the center.

D. Limitations of age, sectarian affiliation, or other factors, as defined by the institution, which affect admissions policies.

II. ORGANIZATIONAL STRUCTURE OF MEDICAL STAFF

A. Responsibility for provision of all medical care in carrying out the medical rehabilitation goals of the center is delegated by the governing board to the medical staff. The medical staff is responsible to the board for assurances of caliber of doctors recommended to the board for staff affiliation and for the quality of medical services provided patients at the center. In all matters of administration, the medical staff is responsible to the director of the center, who personally represents the authority of the board of directors in developing and improving program and rehabilitation services within the center.

B. There shall be an active medical staff, of size appropriate to the center, which shall perform all duties pertaining to the medical staff. The active medical staff shall meet at stated regular intervals, in no event less than six times each year, and full and complete records shall be kept of these meetings.

C. It shall be the responsibility of the medical staff to develop and utilize appropriate procedures for continuing review and evaluation of the practice of medicine in the center by its individual members. Reports of these reviews and evaluations of practice shall be forwarded to the governing body through established channels.

D. An organizational chart of the medical staff shall be available to indicate all committees of the staff, committee functions, membership of each committee, and the administrative function of individual staff members, should there be any.

E. There should be a "professional staff advisory committee" which has the right, in consultation with the chief executive, to direct communication with the governing body. This committee should be composed of the officially appointed heads of each formally established professional service department of the center.

III. SERVICES TO PATIENTS

A. The medical staff of a rehabilitation center is responsible for providing a high quality of medical rehabilitation services for patients in the center who require these services.

B. From its inception and throughout the entire program for each patient, a single responsible individual who is a member of the center's staff should be designated as bearing overall responsibility for the patient's program of rehabilitation. During phases of the program which may be predominantly medical, this person shall be a physician on the medical staff. The rehabilitation chart and record for each patient shall name the individual currently bearing responsibility for the patient. This individual shall serve as direct means of communication between the patient and the rehabilitation team in interpretation of all aspects of the program to the patient, and in bringing greater insight to the patient's problems to the staff.

C. At all times during the course of a patient's rehabilitation in the center, a managing physician from the active medical staff shall be responsible for his medical care and for coordinating all medical aspects of the patient's program. The managing physician shall be responsible for attending any rehabilitation team conferences where the patient's medical problems may be a subject of consideration.

D. Judgment as to diagnosis and treatment rests with the physician responsible for the care of the patient in the center. Where doubt or question as to the best therapeutic measure or adequacy of diagnosis may exist, consultation shall be obtained.

E. Patients in rehabilitation centers for whom outside medical consultation may be need considered appropriate shall be referred only to physicians well qualified by training and experience, in the opinion of their peers, to give consultation in the field in which opinion is sought. Consultation should include actual examination of the patient by the consultant. The record and written opinion of this examination shall be signed by the consultant and made part of the patient's record.

F. Responsibility for providing competent supervision of medical treatment and various therapies shall be fulfilled by duly designated members of the medical staff of the center. The center shall retain responsibility for the quality of medical services or therapies provided outside the center on referral from members of the medical staff when such services or therapies are prescribed as part of the rehabilitation program for the patient.

G. Physicians may prescribe for treatment or therapies within their competence after having examined the patient and satisfied himself as to the appropriateness of such a prescription. A record of this examination and the prescription(s) for treatment in the center, shall be made in writing and kept with the patient's record and chart. Re-examinations for patients undergoing treatment shall be conducted at appropriate intervals in the patient's best interest, and records of these examinations and re-examinations shall be in writing and shall be included in the record and chart of the patient.

H. Patients requiring orthotic or prosthetic appliances as a part of their rehabilitation program must be examined by a physician in order that appropriate prescriptions may be issued. Reports of such examinations and copies of prescriptions shall be in writing and made a portion of the patient's record. Re-examination or checkout examinations shall be conducted to assure proper fit or utility of any appliances prescribed.

I. The medical staff of a rehabilitation center shall fulfill the responsibility of providing constant and organized teaching services to all other members of the rehabilitation staff. In addition, participation in meetings for the purpose of staff evaluation of individual patients, regularly scheduled interdepartmental meetings, and other meetings of general staff interest shall be a responsibility of the medical staff.

J. The patient's personal physician must be fully informed of his treatment, progress, and condition upon the patient's discharge from the center. This shall be accomplished by a written report forwarded, if possible, immediately prior to discharge of the patient, and reinforced by face-to-face or telephone communication. Assistance to the patient in selection of a personal physician, should he not have one, shall be a responsibility of the medical staff. Medical information of a nature to assist in maintaining medical gains achieved at the center shall be made available to the patient's family physician and, where appropriate, outside agencies to whom he may be referred for additional services which may be deemed necessary for him.

IV. PERSONNEL

A. Only physicians licensed to practice medicine in the specific state shall be permitted to practice in the rehabilitation center.

B. Privileges may be extended to qualified physicians to practice in the center in the various specialties, according to their experience, judgment, ability, and competency as evaluated by a credentials committee of the medical staff and recommended to the governing board.

V. RECORDS AND REPORTS

A. A central record or chart containing all diagnostic, therapeutic, and program planing information, shall be maintained and kept up-to-date for each patient receiving services at the center.

B. All records shall bear the signature of an appropriate person for each diagnostic or therapeutic service rendered to the patient.

C. Qualitative staff review of patient records shall be provided at regularly stipulated intervals, and in no event fewer than at least four times each year.

D. Written records shall be kept of all medical staff meetings and of any individual medical staff committee meetings held at the rehabilitation center.

E. Signed progress notes of the patient's condition shall be added, routinely, to the patient's chart.

F. The patient's chart shall include some assurance, in writing, that services prescribed for that patient as part of his rehabilitation program have actually been provided for him, and received by him at the time stated. Such assurance may be in the form of signature of appropriate department heads for each service rendered.

VI. PHYSICAL PLANT

Adequate space and equipment of a nature designed to meet fully the demands and nature of services to be rendered by a medical staff shall be provided.

Where nursing bed care and 24-hour care for sick patients are provided in a rehabilitation center, it shall be accreditable by the Joint Commission on Accreditation of Hospitals.

MEDICAL SERVICES SUBCOMMITTEE (ASSOCIATED MEDICAL)

Chairman:

James W. Rae, Jr., M.D., Chairman
Dept. of Physical Medicine and Rehabilitation
University of Michigan Hospitals
Ann Arbor, Michigan

Lillian E. Chabala, Consultant on Professional Services
American Physical Therapy Association
New York, New York

Alice B. Morrissey, R.N., Instructor in Rehabilitation Nursing
Dept. of Physical Medicine and Rehabilitation
New York University Medical Center
New York, New York

LeRoy W. Nattress, Jr., Executive Director
American Board for Certification in Orthotics and Prosthetics, Inc.
Washington, D.C.

I. GOALS OF MEDICAL SERVICE DEPARTMENTS

A. Rehabilitation Nursing

1. **The metamorphosis of classical nursing skills and procedures into rehabilitation nursing, as with other auxiliary services such as occupational therapy, physical therapy, and provision of orthotic and prosthetic appliances, includes an assumption of full responsibility as a participating and contributing member of the rehabilitation team. Nursing procedures and skills join all other rehabilitation services toward achieving the fullest restoration of sick and disabled persons to their maximum usefulness and optimum health.**

2. **Nursing services within a rehabilitation center strive to provide the highest quality of patient-centered rehabilitation nursing care.**

3. **Nursing services seek to promote and develop dynamic lines of communication with all other areas or services within the center for the best possible realization of each patient's program of rehabilitation.**

B. Occupational Therapy

The goals of occupational therapy services, which are services traditionally considered to be available to all medical specialities on a referral or prescription basis, lie in the direction of maximal physical restoration, psychiatric integration, psychological adjustment, and prevocational evaluation of patients within the rehabilitation center.

C. Physical Therapy

1. **The goals of services provided by a physical therapy department are to combat the cumulative disabling effects of prolonged physical or mental illness, minimize residual physical disability, relieve pain, develop or improve physical skills, and restore function and maintain maximum performance within the patient's capabilities.**

2. **The skills of physical therapy, upon prescription of the attending physician, contribute to the restoration program of the patient and to broader staff understanding of the total problems of the patient and his maximum potential levels of achievement.**

II. ORGANIZATIONAL STRUCTURE OF DEPARTMENTS

A. **Within the framework of a rehabilitation center's general goals and purposes, staff providing each of the auxiliary medical services shall be organized in such a manner as to best provide these services for patients.**

B. **The chief of occupational therapy, the chief of physical therapy, and the chief of nursing services shall each be responsible for assuring the chief of medical services of a consistently high quality of rehabilitation services provided center patients within their departments.**

III. SERVICES TO PATIENTS

A. Nursing Services

1. **Within the framework of a center's goals and admissions policies, a nursing service shall include a full range of care as required by patients treated in the center.**

2. **Clinical instruction in rehabilitation nursing techniques for the nursing staff, as well as teaching services for other members of the rehabilitation staff, shall be provided by a nursing department.**

3. Members of the nursing department shall participate in rehabilitation conferences concerning any patients under their care.

4. The nursing department shall provide consultation and educational services for families of patients to assist them to understand the patient's program at the center, his progress, and his ultimate routine medical needs once he has completed the rehabilitation program set up for him at the center.

5. Nursing services include a conscious, ongoing evaluation of techniques utilized by the department and their effectiveness with relation to patient progress.

B. Occupational Therapy Department

1. Upon referral by physicians to occupational therapy, patients are screened and evaluated to determine feasibility of occupational therapy and its objectives.

2. Services provided by a department of occupational therapy include planning with the patient for immediate and long-range goals toward attaining and maintaining optimal function in keeping with that patient's total individual needs.

3. Occupational therapy services include conditioning the patient for re-entry and integration into the life of his family, and return to a job and to his community-at-large.

4. The staff of an occupational therapy department assists members of the medical staff and other rehabilitation center personnel to understand and utilize occupational therapy facilities within an agency and within a community in order to obtain maximum possible achievement with each patient. This would include, likewise, the ongoing responsibility for educating the entire staff concerning the principles, ideas, and values of occupational therapy for patients.

C. Physical Therapy Department

1. All patients provided service within a physical therapy department are referred there by prescription of a physician.

2. Services provided the patient include a formulation and implementation of realistic short- and long-term treatment goals.

3. The members of a physical therapy department attend staff evaluation sessions for particular patients under their care, and contribute to this staff evaluation by their knowledge of the patient as he is seen in the physical therapy department.

4. Demonstration and teaching programs for the entire rehabilitation staff shall be provided, from time to time, by members of the physical therapy department.

5. A physical therapy department shall maintain an ongoing program for evaluation of services provided to patients within the department and shall strive to improve techniques employed within the framework of their ongoing experience with patients.

IV. PERSONNEL

A. The rehabilitation center shall engage only qualified, professionally trained individuals, in the fields of nursing, physical therapy, and occupational therapy, where these services are provided for patients in the center.

B. The use of aides and volunteers within any of the above departments shall be under close supervision and direction of the head of the department, who shall retain full responsibility for the quality of all services provided within the department by such nonprofessional employees.

C. The head of each of these medical auxiliary services shall consult, from time to time, with the chief of the medical service in the center concerning adequacy of available personnel to provide services, without delay, and to the full extent of need of patients within the center.

V. RECORDS AND REPORTS

A. Each of the three auxiliary medical services shall maintain departmental records adequate to the organization of the department and the scope of services rendered by the department.

B. Records of treatment provided patients by each of these services shall be made a part of the patient's record and chart and shall be available to other members of the rehabilitation team who may be working with the patient. These records shall include all prescriptions or referrals for treatment and patient attendance which served to originate the treatment or attendance.

C. Records and reports shall be standardized within each of the departments, in keeping with the general policies and systems promulgated within the agency. They shall be objective in nature, economical of time and cost, and a protection to the patient and all concerned with his care.

D. Adequate notes of the patient's progress within each of these departments shall be kept and made a part of each patient's record and chart.

E. All administrative, personnel, and patient records kept by each department shall be of such a nature as to contribute readily to periodic reports prepared by the head of each department for submission to the director of the center, and for his use in reporting on the overall program and services provided by the entire center.

VI. PHYSICAL PLANT

Adequate space and equipment of the specific nature designed to meet fully the demands and the nature of services to be rendered within a nursing department, an occupational therapy department, or a physical therapy department shall be provided where such services are part of a rehabilitation center program. Where inpatient services for the sick and infirm are provided at a rehabilitation center, nursing facilities shall meet all basic criteria set up for nursing services within hospitals, as defined by the Joint Commission on Accreditation.

PSYCHOLOGICAL SERVICES SUBCOMMITTEE REPORT

Chairman: Leonard Diller, Ph.D., Chief of Psychological Services
Institute of Physical Medicine and Rehabilitation
New York, New York

Harold Chenven, Ph.D., Chief Clinical Psychologist
Institute for the Crippled and Disabled
New York, New York

George R. Stephenson, Ph.D., Director of Clinical Psychology
New York State Rehabilitation Hospital
West Haverstraw, New York

I. GOALS OF PSYCHOLOGICAL SERVICES

A. The aim of a psychology service is to facilitate the optimum personal adjustment of an individual in the light of his unique physical, intellectual, and emotional capabilities and limitations in relation to his social setting, through the use of psychological techniques, principles, and skills.

B. Psychological services may be rendered directly, through a personal relationship between psychologist and patient, and indirectly, to maintain an atmosphere which recognizes the psychological needs of patients and is conducive to constructive interpersonal relationships.

II. ORGANIZATIONAL STRUCTURE OF DEPARTMENT

A. A psychological service shall be under the direction of a qualified psychologist. The staff shall be organized as appropriate to its size and patient load, and in consideration of the goals of the center, with provision for adequate collaboration with other disciplines.

B. The head of the psychology department is responsible for the administration and professional services of the department. He is responsible to the administrator or director of the agency. The lines of authority regarding administrative and professional functions are clearly defined.

C. Adequate clerical help should be provided to perform routine duties necessary for the operation of the department.

III. SERVICES TO PATIENTS

A. Clinical Services

In the light of his professional judgment, and in consultation with other staff members, the psychologist determines the nature and extent of psychological services which are required by the patient. The full range of the psychologist's skills should be taken into account in referrals for psychological services.

B. Psychological Evaluation

Evaluation is a dynamic, ongoing process of developing and collecting information to contribute to the understanding and management of a patient. The nature and extent of the evaluation is governed by the needs and abilities of the patient in relation to the facilities and resources available for assisting him. The evaluation helps clarify and establish goals for the patient and the rehabilitation team. It affects and influences the approaches to patient management in an unfolding rehabilitation program. Evaluation should include incisive assessment of needs and abilities, intellectual functioning, general and specific assets, and capabilities and emotional adjustment patterns. Methods employed in patient evaluation by the psychologist include:

1. Background information and findings provided by other members of the team.

2. Interviews and clinical observations.

3. Psychological tests such as intelligence, personality, aptitude, interest, and achievement, and specialized procedures for evaluating specific problems in rehabilitation.

The evaluation should contribute to the decision-making process of the rehabilitation team. Evaluation is a continuing process rather than a routine, static procedure carried out only at the beginning of a program.

C. Psychological Therapy

Psychological therapy may be defined as a process designed to assist a patient to develop, modify, and maintain effective and rewarding patterns of behavior and attitudes in meeting the demands of his intrapersonal and interpersonal situation. Two levels of psychological problems which may require psychotherapy can be distinguished in a rehabilitation setting:

1. Psychological problems related to the disability and to the demands and requirements of the rehabilitation process.
2. Psychological problems reflecting long-term maladjustment patterns which impair overall adjustment.

The type of psychotherapy employed should be suited to the patient and his situation. The two forms most frequently used are supportive and intensive therapy with either individuals or groups.

D. Research

The psychologist plans and executes psychological research having practical implications for rehabilitation and/or contributes to our understanding of basic human behavior utilizing the resources of the institution. Research should be in accord with the American Psychological Association ethical Standards of Psychologists Principle 16, research precautions: "The psychologist assumes obligations for the welfare of his research subjects." The psychologist serves a wide variety of roles in other researches carried out at the center.

IV. PERSONNEL

A. Staff members of the psychology department shall have the requisite formal training and experience, as defined by the American Psychological Association and applicable legal requirements, commensurate with their level of responsibilites.

B. Where psychological services are available on an outside consultant basis, the qualifications of the psychologist should be at the same level as those stated above.

V. RECORDS AND REPORTS

Psychologists have the responsibility for communicating their findings and judgments to other members of the rehabilitation staff in both formal and informal manners.

A. Reports should be prepared so as to best communicate data and information about the patient to all rehabilitation staff members in order to achieve a better understanding of the patient, his needs, and his problems.

B. Reports of psychological services should contribute information for practical management of the patient.

C. Care and judgment shall be exercised at all times in preparing permanent records, so as to protect the patient's best interests. Confidentiality of reports of psychological services must be maintained.

D. Communication to other professional staff members should avoid use of raw data without accompanying full interpretive information.

E. The psychologists participate in sessions of oral reporting such as rounds, staff meetings, etc., in which decisions or dispositions are made concerning the patient's welfare.

F. The psychologist should be aware of the consequences of his evaluation by keeping his findings in perspective and pointing out the usable assets and liabilities.

VI. PHYSICAL PLANT

Adequate space including privacy and equipment of a nature designed to meet fully the demands and the nature of services to be provided by a psychological services department, shall be provided.

SOCIAL WORK SERVICES SUBCOMMITTEE REPORT

Chairman: Oscar Kurren, M.S.W., Institute Director
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Post Office Box 391
Winchester, Massachusetts

Vivian Day, Director of Social Services
Rest Haven Rehabilitation Hospital
Chicago, Illinois

Ruth Fennessey, Field Instructor
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University of Chicago
Chicago, Illinois

Margaret G. Holden, Associate Professor
School of Social Work
University of Illinois
Chicago, Illinois

Margaret C. Webber, Chief of Social Services Department
Rehabilitation Institute of Chicago
Chicago, Illinois

I. GOALS OF SOCIAL SERVICES DEPARTMENT

A. The primary goal of social services provided in a rehabilitation center is to enable the patient to understand and profit from, to the fullest degree, the services provided in his rehabilitation program, so that he will achieve that level of social equilibrium which will lead him to a satisfactory solution or adjustment to any and all problems within the interrelated physical, social, emotional, and economic areas of his life situation.

B. Social services seek to discover, identify, and strengthen available group and community resources, outside the rehabilitation center, which may represent supplemental resources, from time to time, in assisting a patient to achieve his maximum rehabilitation potential.

II. ORGANIZATIONAL STRUCTURE OF DEPARTMENT

A. Provision of social services within a rehabilitation center shall be by a department expressly organized for this purpose, whose chief shall be responsible directly to the administrator of the center.

B. The chief of a social services department shall be responsible for defining and establishing the scope of social services to be provided in the center, within the framework of the definition of that center's statement of goals and purposes.

C. The chief of a social services department shall be responsible for the supervision and coordination of the social work staff in the provision of all services provided by the department.

III. SERVICES

A. Social Casework

1. Complete exploration into, and assessment and evaluation of, all social factors, past and present, which may be useful in constructing a clear and revealing profile of the patient in relationship to his need for rehabilitation.

2. Establishment of a working social diagnosis, in order to make available pertinent material bearing on the rehabilitation goals and treatment to be planned for the patient; to define and interpret to the patient, and to those who play or are likely to play a dominant role in his life cycle, appropriate social goals for him; and to select and begin to implement those techniques to be used in his social treatment.

3. Implementation of social treatment, consisting of therapeutic measures designed to assist the patient in achieving established goals.

B. Unification of Staff Resources

1. Contribution and interpretation to the rehabilitation staff of any and all social information exerting any effect, within the professional judgment of those providing social services, on any aspect of problems involving the patient.

2. Through the established avenues of communication within a rehabilitation center, such as individual conferences, clinical conferences, staff conferences, ward rounds, etc., a social services department maintains responsibility for the teaching aspects inherent in handling problems related to specific patients.

3. Through these channels of communication, social services attempt to translate and interpret medical and other types of problems to the patient within the comprehension of the patient's background and experience.

4. Continual sharing of facts, opinions, and judgments, through interservice communications leading to improved techniques of providing services, greater understanding of the patient and his problems, and sharpened acuity of interdepartmental cooperation, understanding, and achievement.

C. Group Work

Less well known, but capable of making genuine contribution to the rehabilitation team, are the services of qualified group workers within the rehabilitation center.

1. Group work services include definition and assessment of areas and experiences within the rehabilitation center which may lend themselves to group techniques.

2. Selection of individual patients, or types of patients, whose rehabilitation process may be assisted or speeded through group experience.

3. Development of program media, including discussion as well as activity, which can provide patients with increased capacity and will to achieve desired rehabilitation goals through group experiences.

D. Interpretation and Evaluation for Rehabilitation Staff

Interpretation and evaluation of social, economic, emotional, and cultural factors affecting specific patients, on an informal, day-to-day basis, with various members of the rehabilitation team as they attempt to provide day-to-day services for the patients.

E. Community Organization and Planning

1. A social services department has responsibility, as the patient progresses in his rehabilitation program, for planning with the outside community for the patient's return to his outside world.

2. Relationships are maintained with any and all agencies who might be able to provide, from time to time, services or any assistance whatsoever to the patient in maintaining and consolidating progress achieved in the rehabilitation process.

3. A social services department shares the responsibility for bringing to community attention lack or inadequacy of services which might be helpful to rehabilitation patients.

F. Education, Training, and Orientation Programs

1. A social services department maintains responsibility for in-service training within the department.

2. A social services department has responsibility for in-center training of other professional personnel, with respect to full understanding and appropriate utilization of social services within the center.

3. There is a responsibility for providing educational services outside the rehabilitation center, in the interest of greater community awareness and understanding of the principles of rehabilitation and services available within the rehabilitation center.

G. Research

1. A social services department has the ongoing responsibility for improvement and refinement of available techniques, as well as development of new methods of care for the complex of social problems affecting rehabilitation patients.

2. Research shall be encouraged into the specific and broader aspects of social services needs of particular patients, as well as types of services requested from community agencies, and criteria for patient referral.

3. Constant research shall be undertaken to test and evaluate services provided, on an individual patient basis as well as on total program basis, within the social services department and within the rehabilitation center as a whole.

4. A social services department has responsibility for devising, establishing, and maintaining channels of follow-up contact with discharged patients, to assure maintenance and consolidation of rehabilitation achievement, and to anticipate and prevent problems arising which might not have been given adequate consideration at the time of discharge.

IV. PERSONNEL

A. Personnel employed in a social services department within a rehabilitation center shall have training and experience consistent with professional standards of training and experience as defined by the National Association of Social Workers.

B. Personnel practices within the social services department shall be in basic accord with policy and practices of the rehabilitation center, and shall provide for job classification and descriptions, appointment procedures, and termination methods and shall specify the system of personnel evaluation and promotion.

C. Policies and procedures of the social services department shall be in writing and shall be available to the social work staff as well as other members of the staff of the rehabilitation center.

V. RECORDS AND REPORTS

A. A record of social services provided shall be an integral part of the record-chart of each patient.

B. Records shall include progress notes, social summaries, resumés of recent developments, and clear analyses of social treatment procedures.

C. Records of the department shall be of a nature and clarity so as to communicate clearly all social aspects of the rehabilitation program of a specific patient to any and all other departments providing services to the patient within the center.

VI. PHYSICAL PLANT

A. Space and facilities, of a nature and design to make possible provision of all services within a social services department, as defined by the stated goals of the institution and the social services department, shall be provided.

B. Space shall include at least some areas, appropriate to the size of the department, for holding individual counseling sessions with patients in an atmosphere of privacy and minimal interruption.

VOCATIONAL SERVICES SUBCOMMITTEE REPORT

Chairman:
C. Esco Obermann, Ph.D., History Project Director
The W. F. Faulkes Memorial Fund
R.R. #4 - Old Orchard
Hastings, Minnesota

Arthur D. Bradley, Ph.D., Chief
Vocational Counseling Services
Veterans Administration Hospital
Minneapolis, Minnesota

Vivian Shepherd, Director
The Rehabilitation Institute
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I. GOALS OF VOCATIONAL SERVICE DEPARTMENT

A. The objectives of the vocational services are stated and defined in writing. The vocational goals are stated objectively and specifically so that they can be observed and evaluated from the processes and operating outcomes at the center.

1. They should be in the form of an official, formalized document signed by the chief administrative officer of the center.

2. They are distributed adequately to referring agencies, to clients, and to the community.

3. They should be available in a form permitting distribution to interested persons and agencies.

B. The stated goals indicated by the department are reasonably within the capacities and the overall purposes and operations of the center.

1. The goals are consistent with the department's operations and with the overall functioning of the center.

2. The written qualifications in the training and experience of the staff would indicate that the stated goals could be realized.

3. The facilities of the center are such as to make feasible the reaching of the goals.

4. The goals are not inconsistent with the stated general goals of the center.

C. The goals of the department are generally understood by the staff and in other departments of the center.

1. Various staff persons give reasonably consistent statements of what the goals are.

    2. Other-than-vocational-department staff are able to give reasonably clear statements of what the goals of the department are.

D. The goals are related to community needs and to the type of clientele usually accommodated at the center.

    1. The goals are consistent with the business, industrial, and professional characteristics of the community.

    2. There is evidence that the goals are shaped in accordance with the identified needs of the referring agencies.

    3. The goals are designed to meet the types of needs that the clientele can reasonably be expected to present.

II. ORGANIZATIONAL STRUCTURE OF DEPARTMENT

A. The vocational services department is organized so that it can effectively reach its stated goals.

    1. The person responsible for the department has the authority to make the decisions for the department's operations and in implementation of its goals.

    2. He participates effectively in other decisions affecting the department, such as those concerning budgeting, staffing, space allocation, travel, client selection, in-service training, use of consultants, public relations, and program development.

    3. He has the same line and staff status as other department heads.

    4. The vocational department has job descriptions of all positions providing vocational services.

    5. The vocational department is responsible for determining the job duties of those persons providing vocational services within the general standards existing within the agency.

    6. The vocational department participates in determining the salary levels of employees who will be providing vocational services.

    7. The vocational department head is responsible for rating employees' effectiveness, promotability, etc., for those persons within the vocational department.

8. The vocational department is responsible for employing and discharging all employees providing vocational services.

9. Vocational staff meetings are routinely held within the vocational department.

10. Adequate amounts of time are available to vocational department personnel for education and research.

11. Organization charts are available which indicate the relationships of the units within the vocational department.

B. The vocational department's role and organizational situation should be such as to facilitate the department's goals as well as the agency's goals.

1. The vocational department has membership on appropriate center committees.

2. The vocational department participates in the determination of meeting agenda for the total staff.

3. The vocational department has opportunity to attend general staff meetings.

4. Appropriate lines of communication are established with other center departments.

5. The vocational department has authority over and responsibility for all vocational services performed in the center.

6. The vocational department has direct access to the chief executive or his designate.

7. Staff members within the vocational department participate in decision-making which affects vocational services.

8. Organization charts are available which indicate the relationship of the vocational department and other departments within the center.

9. The department develops appropriate working relationships with outside agencies and participates in community education and orientation.

C. The administrative relationships within the department are such that each individual working in it knows and understands what his role is, what his prerogatives are, and what his responsibilities are.

1. The supervisor of the vocational services department supervises all center vocational activities.

2. He has direct access to the executive director of the center.

3. There are adequate job descriptions for all employees of the department.

4. There are departmental functional, flow, and organization charts.

5. There are adequate job requirements written for each position.

D. The professional and administrative relationships in the department are organizationally structured so as to be mutually supportive.

1. There is a described and understood basis for resolving intradepartmental conflict.

2. There is involvement of staff in department decision-making.

3. Decisions concerning hiring and firing of department employees are the prerogative of the department.

4. The department has the responsibility and prerogative to prescribe standards for personnel of the department.

5. The department has the responsibility and prerogative to prescribe standards for work quality and quantity of the department.

6. Evaluations of staff are made within the department.

III. SERVICES TO PATIENTS

A. Client Selection

The vocational services department shall be responsible for assuring that all members of the rehabilitation center staff as well as all outside agencies from whom referrals may be expected are informed concerning the range of vocational services available for clients.

1. The sources of referral are identified and informed concerning the capabilities and objectives of the department.

   a. There is evidence in the form of brochures or other communiques to indicate that referral agencies are aware of the scope and function of the department.
   b. The distribution of these items is adequate and appropriate.
   c. The department has available an organization chart covering staff organization and functions of the department that reveals that the functions of the department are being carried out.
   d. Client files should contain evidence that various precedures have been applied, including intradepartment consultations, staffings, and evaluations.
   e. There should be evidence that the results of case conferences, staffings, and evaluations have been communicated to referral sources.

2. The criteria for acceptance of clients are appropriate, clearly defined, and understood by the intake-screening staff.

   a. The intake-screening staff have been instructed concerning the role and functions as well as the limitations of the vocational services.
   b. There is evidence that only those clients are accepted that are properly within the goals and limitations of the department's capabilities.

B. Client Orientation

The vocational services include full orientation of the client concerning those services which may be of assistance to him, the program envisioned for him, and the need for full communication between him and the vocational rehabilitation counselor.

1. There is a procedure for orienting clients concerning the goals of the department and concerning what can be expected from the services of the vocational department.

   a. Written materials, records of interviews, etc., reveal the scope and adequacy of orientation.
   b. There is behavior evidence on the part of the client that the plans involved in counseling have been accepted and acted upon by him. The follow-up information in the client's file indicates that the vocational plans have been followed by the client.

2. There is evidence that the background of the client is sufficiently understood to insure that the orientation given him is effectively communicated to him.

a. Adequate information is obtained from the referral agency referring the case to the center.
b. Case records contain such information as biographical data, medical information, previous appraisals and evaluations, work history material, social service information, etc.

C. Vocational Evaluation

1. Vocational services shall include an evaluation process designed adequately to measure the client's need and readiness for vocational rehabilitation.

   The evaluation process adequately measures the client's readiness and need for vocational rehabilitation.

   a. The counselor's case notes reflect his perceptions as well as those of the client concerning the vocational needs of the client and the client's attitudes and values as they relate to vocational goals.
   b. There is evidence that the client is motivated toward rehabilitating himself, and his behavior during the counseling has been one of cooperation and acceptance as opposed to rejection or noncommitment.
   c. There is evidence by his behavior that the client has been willing to accept the responsibility for decisions that have been made with him and to carry them out.
   d. The case record indicates that the client is ready to deal realistically with his vocational rehabilitation problems.

2. Vocational services and counseling shall include techniques to measure capabilities, potentials, skills, interests, intellectual capacities, and other behavior of the client related to vocational rehabilitation.

   The evaluation process includes techniques to measure vocational potential.

   a. The case record reflects the use of psychological tests which measure such things as abilities, aptitudes, interests, personality characteristics, attitudes, values, and other behavior related to predicting vocational rehabilitation actions subsequent to counseling.
   b. Such evaluation is made by a qualified counseling psychologist or vocational rehabilitation counselor who has the background to evaluate the adequacy of the tests selected and used during the evaluation.
   c. If the evaluation is made by a person not able to evaluate the adequacy of the tests used by the counselor, the tests used are published by reputable test distributors such as the Psychological Corporation, Science Research, Inc., Western Psychological Services, Stanford University

Press, or others listed and evaluated in Buros Mental Measurement Yearbook.

3. Evaluation of a client's maximum potential shall include consideration with other members of the rehabilitation staff of specific medical, social, and psychological factors in the client's history which may contribute to an understanding of the total individual and his total needs.

   a. The evaluation process takes into consideration the medical, social, and psychological aspects of the client.

      (1) The case record indicates that appropriate services have been consulted for medical, social, and psychological recommendations and the consultation information has been utilized and integrated into the vocational plan.
      (2) The overall evaluation is the result of a team effort rather than an individual effort by the vocational services department.

   b. There is adequate provision made for cross information among the various specialties concerned with evaluating the client.

      - There is evidence in case records, conference minutes, consultation notes, and in in-service training meetings that there is substantial cooperation and interplay among services aimed at carrying out the goals of the center and the specific function of the vocational department as outlined in the functional operation document.

4. Where there are limitations of services available for the client within a rehabilitation center, it is the responsibility of the vocational service department to contact, or refer the client to, agencies and facilities outside of the center which may provide the client with additional resources and assistance toward the fulfillment of his ultimate rehabilitation objectives.

   - Assistance outside the department and outside the center is solicited and utilized when the client's requirements are beyond the technical capabilities of the facility staff and/or other facility resources.

      (1) There is evidence in the case records that services not available in the center are obtained from outside the center, such as medical services, psychological services, social services, job tryout, job placement, remedial services, or any obvious services which the client may need in order to successfully rehabilitate himself.

(2) There is evidence in the case records of consultations or referral information from outside of the department or center if a necessary service is required as part of the rehabilitation plan. These might include the fitting of prosthetic devices, speech therapy, vocational training, financial assistance, etc.

D. Vocational Counseling

The basic objective of a vocational service department is to develop a realistic and cogent plan of action for the client to which he subscribes and for which he is willing to take the responsibility for executing.

1. There is evidence in the case record that there is an interchange of information not only among the services within the center itself but between the referral agency and the center both during the initial referral and throughout the evaluation period.

2. The counseling process is sufficiently unstructured to permit development of the client's goals without restricting him.

   a. The development of the vocational plan should be one of collaboration between counselor and client as opposed to a plan imposed upon the client.
   b. Follow-up data in the file indicates the subsequent responsibility or lack of responsibility which the client exhibited in committing himself to his plan.
   c. There is evidence of development of a dynamic, productive relationship between the vocational rehabilitation counselor and the client that develops the client's desire and interest and capacity for maximal effort for the rehabilitation plan which is jointly worked out during the counseling process.
   d. There is evidence that communication flows in both directions during this counseling process and the client is aware at all times that he must accept responsibility for the plans developed during the counseling process.

3. The counseling practices are such as to result in the client achieving orientation, self-knowledge, and motivation, understanding, and acceptance of and final responsibility for the rehabilitation plan.

   a. The records of the client's behavior reveal interest, responsibility, cooperativeness, motivation, acceptance, and understanding of the rehabilitation goal.

b. There is evidence from the various persons working with the client during the evaluation that he has these positive attitudes, not the opinion of just one person such as the counselor.

4. The counseling process is directed toward a realistic plan for action.

   a. There is evidence that a logical sequence of evaluations, appraisals, and counseling sessions with the client lead to a realistic and acceptable objective which the client assumes the responsibility for implementing.
   b. There is follow-up information indicating the subsequent outcome of the counseling plan accepted by the client. Outcomes are shown to coincide with plans as found in case summaries.
   c. The plans appear to be individualized for each client, based on labor market needs and the individual characteristics of the client.
   d. The plan is something that has been or can be implemented for the client.

E. Vocational Training

Vocational training within a facility has the responsibility of providing evaluation and appraisal information as well as skill training, education, developing work tolerance and habits, socialization, and the development of other behavior essential to the rehabilitation goal that has been worked out through the services of the center. Where vocational goals are part of the rehabilitation plan the vocational services department will coordinate the vocational training functions involved.

1. The training program is such as to permit the development of the skills prescribed by the training program.

   a. The training develops a particular skill that has direct transference to a job being considered for the client.
   b. The training is meaningful, purposeful, and implements a plan outlined by the client and counselor.
   c. Unless specified for a particular reason, the vocational training should be vocation-goal oriented rather than diversional in nature.

2. The training provides for continuous observation, evaluation, and development of the client.

   a. The training provides "feedback" information which will be useful to the counselor in deciding whether to continue, change, modify, or discontinue the vocational training plan.

b. Both subjective and objective methods are used for rating progress and development in the program.

c. There is a method based on some criteria of performance, such as achievement, production, or accomplishment, to give indication as to when the client has reached optimal benefit from the training.

3. The devices utilized for the measurement of progress are adequate.

    a. Objective and subjective measures used are valid measures of achievement or progress.
    b. The devices to measure achievement or progress are standardized so that they can be applied with reliability from client to client.
    c. The information as to the client's progress is relayed to the vocational services by reports.

4. The training plans are consistent with the vocational goals set through counseling.

    a. The training plan is logical in light of the goal set up for the client by the vocational services.
    b. The training relates directly to the client's plan upon leaving the center for either further training or employment where the training has been prescribed for vocational reasons.
    c. In addition to skills evaluation, training, and education, the training also serves the function of establishing work tolerances.
    d. The training allows for the client's growth through socialization by working with peers, evaluators, and others.
    e. Behavior is noted by the evaluators to indicate characteristics related to future performance in training or on the job such as motivation, ability to get along with supervisors and other workers, ability to profit from training, work habits, and personal factors which would be important in future adjustment in training or on the job.

F. Work Tryout and Experience

The vocational services department of a rehabilitation center is responsible for the broad development of community employment possibilities related to the counseling needs of the clients it serves. It works with other community placement agencies and facilities in a dynamic and expanding way in widening the vocational opportunities for its clients. Successful work experiences are the end products of successful client vocational evaluation, appraisal, and counseling experiences.

1. The work environment provides for an adequate range of observations and skill evaluation.

    a. Where work tryout has been used, the case records reflect meaningful assignments related to further extension of the counseling services in their assessment and evaluation of the client toward his goal of gainful training or employment.
    b. The range of activities offered and assessed through work tryout serve the needs of the client referred for this type of experience.

2. The work experience has as one of its objectives to evaluate work habits, tolerances, motivations, and personal characteristics of the client as they relate to future vocational goals.

    a. There is in the record an ongoing evaluation of the client's progress in the work situation as it relates to behavior that is essential to successful job performance.
    b. As part of the work experience provisions are set up for the modification of or development of personal characteristics and behaviors necessary to make the client a better performer in a subsequent training or work assignment.

3. The work experience leads to a successful bridging of the gap from workshop experiences to gainful employment in the labor market.

    a. The workshop experiences are realistic in terms of the client's ability to bridge the gap from center experiences to successful vocational experiences.
    b. Follow-up information in the case records should indicate that the work experiences have contributed to the client's subsequent success.

4. The range of experiences offered in the work program, the skills of the evaluators, and the opportunity to learn good work habits and skills are adequate to the goals prescribed by the vocational counselor in his use of work evaluation as a technique in his vocational counseling armamentarium.

    a. The workshop experiences are meaningful and related to subsequent performance in training or work in the community.
    b. A review of the client's file indicates that the work experience was a necessity and in some cases a sufficient condition to his later successful performance on the job or in training.

5. The opportunities offered in the work experience or tryout are related to and compatible with the economic, manpower, and employment needs of the community.

    a. The workshop experience is a dynamic one related to subsequent employment of the client.
    b. The workshop tasks or duties are similar to those found on actual jobs now available in the local labor market.
    c. The workshop or work experience adds information to the counseling process which has helped the client and counselor make a decision as to future plans and goals for the client.
    d. There is adequate compliance with the referral communication which prescribes the work experience.

G. Placement

Successful placement or training is the major goal of the vocational services department. Successful placement or training for the client as well as the employer or the referring agency is the ultimate and logical conclusion to the most successful counseling relationship for a client.

1. The placements utilize the client's aptitudes, abilities, skills, experiences, and interests.

    - There is evidence in the follow-up evaluations as to whether or not the placement is a successful one for the client and the employer.

2. The placement service is related to the overall plans and goals of the client, the department, and the center.

    - The placement of the client reflects the successful end product as developed through his experiences, plans, and decisions in going through the center as part of the process of rehabilitation.

3. If the placement is done by the vocational services and if there is a placement specialist, he is under the direction and supervision of the vocational service department.

    a. The placement specialist or the vocational counselor relates effectively to the other specialists who have been involved in the development of a vocational goal for the client.
    b. The client's record indicates that the placement specialist is aware of the client's abilities, limitations, and experiences in the placement of the client.

   c. The record indicates that the person responsible for the client's placement has participated in staffings, has inquired about it, and is aware of the client's placement needs.
   d. The records make it possible to guage what proportion of clients obtain and remain on a job.

4. Placements are realistic and ethical from the employer's perspective.

   a. The placements made are such that the needs of the client as well as the employer are met in a satisfactory manner.
   b. There is evidence in the case records as to the placements that show success on the job.
   c. The records show the extent of reassignments, employer complaints, and poor job performance due to poor placements.

5. There is appropriate orientation of the client to the job and orientation of the employer to any special needs of the client, if any.

   a. The case records indicate that a failure of a client on a job is studied by the placement person for the purpose of designing better service.
   b. There is evidence in the record of the steps taken by placement specialist in placing the client on the job.
   c. There is normal procedure for the placement specialist to follow-up with both client and employer for a reasonable period of time after placement.
   d. The center assumes the responsibility for replacement of a client who has failed because of some conditions or factors not originally perceived in the evaluation or placement of the client.

6. Where the agency does not have a placement service, the vocational services department assumes the responsibility for referral to the appropriate agency having placement services.

   a. Where there is no placement service, the records show that the case has been referred to the appropriate agency with the necessary information about the client to effect a realistic and successful placement, if placement is indicated.
   b. There is evidence in the record that some plan has been put into effect to "feedback" information on cases referred for placement.

H. Employment Follow-Up

1. The follow-up activity should have the client as its primary focus.

a. Follow-up identifies problems of the client that need additional professional services.

b. The case records show to what extent problems uncovered in follow-up are given the attention needed.

c. Follow-up techniques permit evaluation of job success, of job satisfaction, and of the effectiveness of the vocational services department.

d. Follow-up is timely and flexible enough to meet client needs.

2. Follow-up services should be comprehensive and adequate for requirements.

   a. Records of follow-up contacts are adequate and available.

   b. There is evidence that the employer is interviewed if employment is involved.

   c. There is evidence that the client is interviewed to learn of current problems.

   d. Interviews are under circumstances that permit the acquisition of the information needed.

   e. If follow-up is to an agency, institution, or professional person, provision is made to evaluate the referral.

3. When provision is made for some other agency to take over the follow-up function the center continues its interest in the client.

   a. There is evidence of a formal arrangement with the other agencies.

   b. There are records of "feedback" agencies.

I. Research and Self-Evaluation

1. Professionally competent and appropriate research and self-evaluation of the vocational services is an accepted practice within the vocational department.

   a. The vocational department staff have sufficient time and opportunities for research and self-evaluation.

   b. Research and self-evaluation are regularly occurring functions of the vocational department.

   c. Research and self-evaluation studies are performed with accepted and recognized techniques.

   d. Technical assistance is available and utilized for research and evaluation.

   e. The research and self-evaluation functions are consistent with department goals.

   f. Results of research and evaluation are discussed, evaluated, and, when appropriate, implemented.

   g. Provision is made for publication of research.

2. The scope of research and self-evaluation should include an evaluation of services outside the vocational department.

   a. The vocational department participates in and encourages interdepartmental and interagency research and evaluation studies.
   b. The vocational department makes full use of its research findings as well as those of other departments and outside agencies, institutions, etc.
   c. The vocational department research and self-evaluation concerns itself with studies of agencies, employers, and other organizations providing services or contacts with clients served at the center.
   d. The research and self-evaluation concerns itself with studies of the goals, problems, and functions of the vocational department.

IV. PERSONNEL

A. The ratio of staff to clients is within optimal limits.

1. Enough time is provided so that the needs of the client are met by those serving him.

2. The range of duties of each staff person is appropriate to his position and training.

B. The training, experience, and competency of each staff member is consistent with high acceptable standards in his specialty field.

1. Vocational rehabilitation counselors shall be graduates of approved programs in vocational counseling or have equivalent training. They should be members of or be eligible for membership in the National Vocational Guidance Association (M.S. degree).

2. Staff personnel with less preparation for counseling than a Masters degree in guidance counseling, or the equivalent, they shall have their vocational counseling systematically and periodically supervised, both directly and indirectly, by staff persons who meet the qualifications above, and the supervision shall be in proportion to the amount of professional preparation and experience such staff personnel have. All vocational counselors must have a B.S. degree.

3. If standardized psychological tests are used in vocational counseling, counselors shall use these tests in light of the technical recommendations for psychological tests and diagnostic aides of the American Psychological Association.

4. The professional supervision of vocational rehabilitation counselors in the performance of their counseling duties shall be provided primarily by vocational rehabilitation supervisory staff.

C. Employees are regularly evaluated with respect to their work and their competencies and incompetencies are revealed and communicated to them.

1. Job requirements have been written for each position by the vocational services department.

2. These requirements are adequate, appropriate, and objective.

3. There is evidence that the evaluating person has sufficient contact with each employee to evaluate him with validity.

4. A performance evaluation is made at least once each year by the person responsible for quality of staff performance.

5. The evaluation is reviewed by the supervisor of the evaluator before it is communicated to the employee.

6. The evaluation is written, and in such terms as to reveal competencies and incompetencies and the data or observations on which judgments are made concerning these competencies incompetencies.

7. Constructive interviews are held with the employee concerning the evaluation of his work.

8. Performance evaluations form the basis for promotion, reassignment, and release.

D. Provision is made for continuing in-service training of the staff.

1. Training programs are written, appropriate, and delivered by competent means.

2. Appropriate professional books and literature are easily available to the staff.

3. There is provision made for release of staff to take training.

4. Other appropriate in-service training-supportive provisions are made to encourage such training.

5. Travel money is made available for staff to attend their professional conventions.

E. The personnel of the department participate in available training opportunities, attend their professional conventions, read their professional journals and books, and belong to appropriate professional organizations.

   1. The staff is involved in the development of its own in-service training program.

   2. There is evidence of staff participation in the program.

   3. Appropriate journals and books are read by the staff.

   4. Professional staff belong to appropriate professional organizations.

   5. There is evidence of participation of staff in local or other activities of their professional organizations and related groups.

F. Staff resources supplemented by consultants where staff competencies are deficient.

   1. Consultants of high competency are utilized in the work of the vocational services department.

   2. Consultants are regularly made available for staff training.

   3. Consultants are employed to teach or give demonstrations of methods and techniques.

   4. Consultants are used to help in program development and research.

V. RECORDS AND REPORTS

A. Vocational department records should provide information necessary to evaluate the contribution of vocational services provided to the client.

   1. The records contain information which indicates the client's assets, liabilities, and capacities to profit from vocational services.

   2. The records state the goals of the vocational department for each client.

   3. The records provide information reflecting the services which the client received.

4. The records indicate the outcome of those services provided by the vocational department.

5. The records contain follow-up information on the client.

6. The client records available from the units within the vocational department are organized in such a manner as to offer a unified description of the client, the process, goals, outcome, and follow-up.

B. Vocational department records and other center records should be available to qualified personnel.

1. All center client records are available to the vocational department.

2. Vocational department client records are available to other center staff.

3. Vocational department reports are written in such a manner that they are understood by other center staff.

4. Records kept are consistent with the need for such records.

5. Appropriate regulations are in effect which restrict the records to authorized personnel only.

6. Vocational services information is maintained in a section of the client's chart which is assigned for vocational department use.

7. The vocational records are maintained in such a manner as to indicate the services rendered, the date the service was provided, and the identity of the person giving the service.

8. Reports of vocational services and outcomes are completed and available at regular intervals to appropriate agencies, institutions, and professional persons outside of the center.

VI. PHYSICAL FACILITIES

A. The building and equipment available to the vocational department are adequate to permit efficient realization of goals.

1. Each staff person has an adequate office where he can see clients, as required, free from distraction and interruption.

2. The office and work spaces are clean, of reasonable dimensions, uncluttered, and attractive.

3. Tools and equipment are adequate and in good condition.

4. Files and storage are adequate.

5. The furniture is in good and functional condition.

B. Library and other materials are available and easily accessible.

1. The library materials are centralized, catalogued, and kept current.

2. The library is quiet, well lighted, and free from distraction.

3. Technical materials are appropriate, complete, and properly safeguarded.

C. Proper care and protection are provided for equipment and supplies.

1. Fire and loss hazards have been eliminated.

2. Restricted materials are secured against unauthorized persons.

APPENDIX III

SERVICES, COMPONENTS, AND PERSONNEL

1. MEDICAL SERVICES

Components	Personnel
Medical Evaluation Medical Treatment	Physicians
Physical Therapy	Physical Therapists
Occupational Therapy	Occupational Therapists
Nursing Care	Registered Nurses
Prosthetic Fitting	Prosthetists

2. PSYCHIATRIC, PSYCHOLOGICAL, and SOCIAL SERVICES

Components	Personnel
Psychiatric Evaluation Psychiatric Therapy	Psychiatrists
Psychological Evaluation Individual Psychological Therapy Group Psychological Therapy Personal Adjustment Counseling	Psychologists
Social Evaluation Social Casework Social Groupwork	Social Workers

3. VOCATIONAL and EDUCATIONAL SERVICES

Components	Personnel
Vocational Evaluation Vocational Counseling	Vocational Evaluators
Job Tryout Formal Job Placement	Vocational Rehabilitation Counselors
Formal Vocational Training	Vocational Instructors
Sheltered Workshop	Workshop Foremen
Preschool Education Elementary Education Secondary Education	Academic Teachers

4. SPEECH and HEARING SERVICES

Components	Personnel
Speech Evaluation Speech Therapy	Speech Pathologists
Audiological Evaluation Audiological Therapy	Audiologists

APPENDIX IV

CERTIFICATION OF SERVICE UNITS

American Board for Certification in Orthotics and Prosthetics
919 Eighteenth Street, N.W.
Washington, D.C. 20006

American Board on Counseling Services, Inc.
1605 New Hampshire Avenue, N.W.
Washington, D.C. 20009

Professional Services Board
American Speech and Hearing Association
1001 Connecticut Avenue, N.W.
Washington, D.C. 20006

APPENDIX V

MAJOR NATIONAL ORGANIZATIONS RELATED TO REHABILITATION FACILITY PERSONNEL*

Academic Teacher:

National Education Association
1201 Sixteenth St., N.W.
Washington, D.C. 20006

Medical Record Librarian:

American Association of Medical Record Librarians
840 North Lake Shore Drive
Chicago, Illinois 60611

Nurse:

American Nurses' Association
10 Columbus Circle
New York, New York 10019

Occupational Therapist:

American Occupational Therapy Association
250 West Fifty-seventh St.
New York, New York 10019

Physical Therapist:

American Physical Therapy Association
1790 Broadway
New York, New York 10019

Physician:

American Medical Association
535 N. Dearborn St.
Chicago, Illinois 60610
(Local Medical Society)

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*This list represents those organizations with primary identification to personnel listed in appendix III. It is recognized that there are other occupational groups represented in rehabilitation facilities.

Psychologist:

American Psychological Association
1200 Seventeenth St., N.W.
Washington, D.C. 20036

Social Work:

National Association of Social Workers
95 Madison Ave.
New York, New York 10016

Speech Pathologist:

American Speech and Hearing Association
1001 Connecticut Ave., N.W.
Washington, D.C. 20006

Vocational Rehabilitation Counselor:

American Rehabilitation Counseling Association
1605 New Hampshire Ave., N.W.
Washington, D.C. 20009

National Rehabilitation Counseling Association
1029 Vermont Ave., N.W.
Washington, D.C. 20005